UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF NEW YORK
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PETER ALLEN, *et al.*,

Plaintiffs,

v. 19 Civ. 8173 (LAP)

CARL KOENIGSMANN, *et al.*,

Defendants.

Trial

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New York, N.Y.
September 6, 2023
9:00 a.m.

Before:

HON. LORETTA A. PRESKA,

District Judge

APPEARANCES

AMY J. AGNEW
JOSHUA L. MORRISON
VERONICA JOSIAH-ARYEH
Attorneys for Plaintiffs

WHITEMAN OSTERMAN & HANNA LLP
Attorneys for Defendant Moores
BY: WILLIAM S. NOLAN
ORIANA L. KILEY
GABRIELLA R. LEVINE
JENNIFER M. THOMAS

Also Present: Baron Jones, Law Student Clerk

(Trial resumed)

THE COURT: Good morning, who do we have?

MS. AGNEW: Good morning, your Honor. Plaintiff class would like to call Dr. Adam Carinci.

ADAM JOHN CARINCI,

called as a witness by the Plaintiffs,

having been duly sworn, testified as follows:

THE DEPUTY CLERK: Please state and spell your name for the record.

THE WITNESS: My name is Adam John Carinci, C-A-R-I-N-C-I.

THE COURT: Ms. Agnew.

DIRECT EXAMINATION

BY MS. AGNEW:

Q. Good morning, Dr. Carinci.

A. Good morning.

Q. Why are you here today?

A. I'm here to testify in this trial with regards to 70 essential inmates that are claiming mistreatment with regards to medications with potential abuse potential.

Q. Could you go through your educational background for the Court. You don't have to give us all your grades. We just want to know where you went to school. Let's start with undergraduate education, please.

A. So undergraduate is at Pace University. I did a

biochemistry degree. I then moved into medical school at Johns Hopkins University School of medicine. This was followed by residency in anesthesiology, critical care and pain management also at Johns Hopkins hospital.

My final year of training was at Massachusetts General Hospital and Harvard Medical School with a fellowship in pain management.

Q. Okay. And during the course of your education or at any time thereafter did you hold any teaching positions?

A. Yes. So when I finished my fellowship, I stayed on faculty at Harvard Medical School at Mass General hospital. I was an assistant professor there. I had responsibilities for teaching medical students as well as interns, residents and pain management fellows for approximately seven years while I was on staff there.

I then in my current role at University of Rochester Medical Center I have similar responsibilities. I'm an associate professor of anesthesiology and pain management. I also teach medical students, residents and fellows.

Q. When you were teaching at Harvard Medical School, sir, did you give any lectures?

Did you publish?

A. Yes, I gave many lectures on a monthly basis, so these were ongoing lectures with regards to various aspects of pain management. I also did publish book chapters as well as

several articles in pain management journals throughout that time.

Q. Can you tell me, sir, just for those in the room who may not know, I think you mentioned training in anesthesiology and in pain medicine, are those two separate disciplines?

A. Yes. So anesthesia is my primary board certification, and that is a general grounding in aspects of pain management.

But in terms of specialization, in terms of being able to practice the area, the specialty of pain management, one would have to pursue a fellowship, which is an additional year of training that is very specific and focused on the area of pain management.

Q. And I want to be clear because I don't always understand the distinction. When I think of an anesthesiologist, I think of the doctor who's in the operating room.

Is that what you do, sir, in your daily practice, you go into operating rooms and put people under?

A. No. In the early parts of my career, that was something I did. Now I'm engaged entirely in the practice of pain management, which is essentially outpatient, pain management, dealing with medication, prescriptions, interventional procedures, essentially just dealing with the area of pain management, and not at all dealing with operating room anesthesia as you're referring to.

Q. And so as at this point in your life, for how many years

have you been treating patients in pain management?
A. I finished my fellowship in 2009, so since then continuously.
Q. In what states do you hold medical licenses currently?
A. Now just New York.
Q. Where did you previously hold medical licenses?
A. Massachusetts, Louisiana and New York. I've since let Massachusetts and Louisiana -- I just didn't renew them. I let them lapse.
Q. Have you ever had any blemishes on your medical licenses?
A. No.
Q. To your knowledge has anyone ever complained to any medical review boards or professional associations about your practice?
A. No.
Q. Can you tell me, Dr. Carinci, over your career approximately how many patients have you seen and treated -- and I'm not asking for a concise number -- in the area of pain management?
A. Well-over 10,000 patients.
MS. AGNEW: Your Honor, the plaintiff class moves to qualify Dr. Adam Carinci as an expert in pain management.
MR. NOLAN: No objection, your Honor.
THE COURT: He is so qualified.
Q. Dr. Carinci, for this case, can you tell me what's your understanding of why we hired you?

A. I was hired for two primary reasons. The first was to review MWAP policy and how it was instituted in regards to the named plaintiffs in this case, and to ascertain whether that was consistent with the standard of care.

The second area was to review the reassessment process to determine whether that was done appropriately and consistent with best practice.

Q. And when you talk about looking at the MWAP policy, I think you just said the named plaintiffs, but was your study isolated to the 18 named plaintiffs?

A. No.

Q. First of all, let's just start, did you publish a report of your findings in this case?

A. Yes.

Q. And so what I'd like to do is talk about the things that you examined before you wrote your report in order to come to the conclusions that you did.

A. Okay. Beginning with the medical records was the primary evaluation. So given the voluminous amount of records in this case, I had asked that your firm provide summaries of the patients, which I could then use as a 10,000-foot view or springboard to really delve into the substance of each patient's record.

And from there, I reviewed MWAP forms, the medical records, and really the entirety of their chart to come to my

conclusions.

Q. When you say you reviewed the entirety of their chart, isn't it true we created, meaning my office, subsets of the medical records for you at your direction?

A. Yes. So, again, when I was asking to engage in this, I understood there was a timeframe that was of the essence given that there was some number of patients that were being harmed potentially and that time was of the essence in putting this together.

And so to make my time and my ability to actually process through the records, I had asked that -- again, there were certain particular areas that I wanted to look closer at again with that 10,000-foot view. And if you could provide that to me and then also references to the underlying medical records so that would be fruitful to me in being able to effectively process it.

And I'll just open my report if you don't mind to again review those particular areas.

Q. We just want you to refresh your recollection, but not read your report, sir, okay.

A. Yes. Just as a matter of reference, page nine, there were nine things --

Q. Let's stop, Dr. Carinci.

MS. AGNEW: Mr. Manly, to your right is a set for the judge.

THE COURT: Thank you so much.

Q. Please continue, Dr. Carinci.

A. Just to be more specific about what I had asked you, again, there were nine particular things that I wanted you to focus on, and I'm happy to read those if you'd like me to, but really they're on page nine, patient file review, subsection A, nature of the files reviewed.

So there were these multiple areas that I really wanted to delve into in order to answer the questions I was asked to be answered.

Q. To assess kind of the history of pain management, why were those particular records necessary for you to look at?

A. I understood early-on that the critical aspect of this were with regard to medication with potential abuse, and whether these patients were inappropriately discontinued on their medication and was their medical rationale for doing so.

In order to really be able to answer that question, I had to dig through information about, for instance, any issues with drug abuse, any history of what was their primary diagnosis while they were there, what type of diagnostic testing had been established for instance, what type of medications were they on and was there any indication that those medications were successful in improving pain and improving function.

Were there any specialist consultations and

recommendations thereof. Importantly, I wanted to know about the MWAP request forms and were those available for the particular patients, and so on and so forth, really just delving into a broad view of the patient's history, and then with the ability to dig deep to formulate my own conclusions about that.

Q. Can you explain to the Court your understanding of what an MWAP request form is in the context of this case?

A. So the patients were being treated -- I'll refer to it like the first level provider or the primary provider within the system that would determine whether they were a candidate for one of these medications.

So medications with abuse potential is or was a list of medications that were deemed to have potential abuse liability, and it ranged from things like gabapentin up to things like opioid, such as percocet and hydrocodone, and various sort of things within.

And the MWAP request form was completed by this first level provider if they were examining the patient and they thought the patient was a candidate for one of these medications. They would complete one of these forms.

And it was my understanding that that form would then circle up to what was called the regional medical director who would essentially be able to give a thumbs up or thumbs down, a yes or no, with regards to that medication.

Q. When you were working on your report, did you review all of the MWAP request forms?

A. No. There was at minimum it seemed over 10,000 of these MWAP request forms. So again, in order to make my time fruitful and to be able to efficiently process through the volume of information, I again asked your office to put that information into a much more easily read format in a summary essentially of those forms.

So that I could again get a general sense for what was the outcome of those requests, again in a general sense, and then be able to take a very deep dive when needed and wanted on particular patients.

Q. Can you tell me when you were looking at medical records and the summaries we created, did you rely on my office's summaries?

A. No, not at all.

Q. How did you use the summaries?

And I apologize. You explained a little bit, but I want the record to be extremely clear as to how those summaries were used by you?

A. Again, I think if we just take a step back, I been trying to answer the questions that we've talked about. There was at least 225,000 pages of medical records here that we're dealing with.

So I asked you to put together a brief summary of each

of these patients with references to the underlying medical records. And I didn't ask for any interpretation. I just ask for raw factual data with regards to pertinent dates, medication names and general history of the patient.

From there, I would read that summary to just garner a really high level what I would call a 10,000-foot view of patient X. From there, I would then delve into the underlying medical records to synthesize that information and formulate my own opinion. So your summaries were again simply factual information that I checked against the medical records, but did not rely on in formulating my opinions.

Q. When you looked at these summaries and in certain instances contrasted them with the medical records, were the summaries perfect?

A. No.

Q. And did you at any time believe that the summaries were being created by medical professionals?

A. No.

Q. So other than the medical records in the MWAP request forms, what other sources of evidence did you use before you drafted your report?

A. Well, for 17 of these individuals, I personally examined them. So on several dates I went out to the facilities where some were located and interviewed them, performed an examination of them, spoke with them, had access to their

medical records, both before and during.

And so that was also a significant portion of my understanding that garnered additional information from that.

Q. Dr. Carinci, why didn't you go and physically examine each one of the patients that you speak about in your report?

A. I think first off I didn't specifically request to see any one particular individual or all of them. I was available to review whoever was available to be seen on those dates.

And I think you worked with the defense in determining who was available to be seen, what was the time which we could accomplish this.

And I think also importantly, this was during the sort of early days of Covid and there was a lot of restrictions at these facilities about who could enter and for what purpose. And so I think the logistical barriers were quite enormous even to accomplish this evaluation of 17 of them, let alone all of them.

Q. And I just want to walk through generally what your encounter was like and how you conducted it with any one of the 17 who you did physically examine?

A. I'm sorry. Could you ask me again what is it you're looking for specifically.

Q. I'd like you to explain to the Court in one of these encounters where you went into a facility and examined a patient, what steps did you take? What did the encounter look

like?

I'm looking for, did you do it as you might have done for any patient in your own office?

A. Yes. To the extent possible, I essentially simulated how I would examine and determine the course of treatment for a patient who would come to see me in my own clinic in the community.

And so I brought a reflex hammer, ability to test strength and sensation. I performed a subjective interview with the patient, kind of going in with knowledge of their history already from their medical records. And so getting a subjective sense of their pain, how they're describing their pain, their location, the severity, importantly functional measures of what they're able to do, again from a subjective standpoint.

From there I moved into objective evaluations, which are what I would consider a musculoskeletal and neurological exam, which would be no different than I would perform with again a patient that was seeing me in the community. So I'd be looking at muscle strength, sensation, reflexes, range of motion, tenderness, any sort of dysfunction of muscle atrophy. Those would be the various things I would look at.

From there I would then move into my assessment of the patient, having an understanding of what medications they're currently on, what medications they were on in the past; where

is their function relative to memory in the past or current; and then formulating a plan forward in terms of medications that worked and where we could go in the future from an assessment.

Q. Did you speak with the patients when you met with them to examine them?

A. Yes.

Q. What were you looking for when you spoke to those patients?

A. I think in general I want to know their again subjective and objective findings.

So from a subjective standpoint, I simply want to know, hey, what is your pain score at rest, what is your pain score with functional movements. And so when we talk about a pain score, we're really talking about a range of zero to ten is a very simple one. Zero is no pain. Ten is the most severe pain, and just getting a sense of where they sort of self-assess on that scale.

Pain location. I would want to know then the etiology of the pain, so what type of data was available for me to corroborate their systematology. And so I'm not -- I think any physician in my specialty doesn't just accept what the patient says at face value. We're looking to corroborate their subjective complaints with objective findings. And so that really was always the goal to corroborate what they're telling me subjectively that I'm having X, Y and Z problem, with the

objective data. And so that's really the role that I'm playing there.

Q. Before we get into the heart of your report and your conclusions, can you tell me were there any patients you examined who you felt did not need to be included in the report; and if so, why?

A. Yes. There were two patients that I thought did not have -- they did not meet the criteria for medication with abuse potential. And that was Mr. Ernest Iverson and Mr. Jose Torres were two of those.

And it really came down to I guess in the simplest way, their subjective complaints were not corroborated by objective data.

Q. And so then why did you determine not to include them in your report?

Were you trying to skew your data? Were you trying to skew your results?

A. No, it wasn't a means of trying to skew data. The point of this exercise really was to determine who was a candidate for medications with abuse potential, and was that policy as applied to them done in a manner that was consistent with the standard of care.

And so if someone was not a candidate in my opinion for those medications with abuse potential, then they really -- it was really irrelevant whether the MWAP was applied to them

in a manner that was consistent with the standard of care because we were really looking to see who was actually wronged in this scenario.

Q. And can you tell me, Dr. Carinci, before you started drafting your report, did you rely on any assumptions?

A. Yes, I did rely on several assumptions which I outlined in page two of my report. I'm happy to go through those with you if you'd like, or I'll just leave it at that. I did outline my assumptions on page two.

Q. Why don't you just run through and summarize them briefly for the Court, and then let's talk about the importance of these assumptions or why you felt it was necessary to include them in the report, okay.

MR. NOLAN: One quick objection. It's not really an objection, bug if he's going to be reviewing the report in this detail rather than just refreshing recollection, should we enter it into evidence.

MS. AGNEW: I'm happy to enter into evidence, your Honor.

THE COURT: What do you want to call it?

MR. NOLAN: Just to be clear, it's just the text of the report, not the underlying --

MS. AGNEW: Sure. Your Honor, in your bound copy it's going to be the actual report itself is up to Exhibit 1, so that will be pages 1 through 47. We're going to call that

P137, and let me quickly lay the foundation.

Q. Dr. Carinci, what I have not marked, but have just said will be Plaintiff's P137 is in that bound copy in front of you of pages 1 through 47.

Sir, do you know what that document is?

A. Yes.

Q. What do you know that document to be?

A. This is my expert report.

Q. And, sir, did you draft that document?

A. Yes, I did.

Q. And did you draft that document after you examined and studied the evidence that you've explained to the Court here today?

A. Yes.

Q. And, sir, is that your signature on the last page of the report?

A. Yes.

Q. Did anyone else write this report?

A. No.

MS. AGNEW: Your Honor, I'd like to enter into evidence Plaintiff's 137 which is the expert report of Dr. Adam Carinci.

MR. NOLAN: No objection.

THE COURT: Received.

(Plaintiff's Exhibit 137 received in evidence)

BY MS. AGNEW:

Q. If you could just run through the assumptions. We don't need to go into terrible detail, but we do want to understand.

A. Certainly. So the first assumption is this MWAP policy was really put forth on June 1, 2017. That was the date on the policy itself.

It was also clear though as I was reviewing these records that a lot of this treatment had preceded that date, and a lot of the medication discontinuation had preceded that date by many years. So I just wanted to indicate my assumption that this looks like this process had been sort of going on for some period of time.

My second assumption is that really in order to get one of these medications that there had to be a form, an MWAP request form that was filled out, and that it was circled up to the regional medical director for ultimate approval on that. I outlined who those folks were in the records that I reviewed.

I also assumed that in some instances the chief medical officer were able to review those forms as well, just really who was the decision maker with regards to the ultimate decision about terminating medication or issuing medication.

I made an assumption with regards to reassessment, which was the process undertaken by DOCCS in the fall of 2020, where providers were filling out these chronic pain and MWAP reassessment forms, that they were really only instructed to

view one year of the patient's medical records at the time they were doing it.

I assumed that patients in DOCCS's custody could not arrange their own specialty visits. I also assumed that those FHS1 entries that I reviewed were not in the chart, and they were maintained in a separate database.

I assumed that in most instances the RMDs did not have access to the patients' charts, only that FHS1 system, and really those were my main assumptions.

Q. Why do you disclose assumptions in an expert report?

A. Well, I think I want to set the stage for my background and understanding as I put the report together, sort of where I was coming from.

I think it's always important when you're evaluating data to provide the assumptions as you're interpreting that data so that we're all on the same page.

Q. So I'd now like to turn to your opinions. Let's do this. Why don't we start with the standard of care just cause I think it lays a nice landscape for then your opinions and conclusion.

Could you please explain to the Court your expert opinion of the standard of care for the treatment of chronic pain?

A. I'm sorry. I was just flipping through the report. Can you ask the question again.

Q. I can. Can you explain to the Court in your expert opinion

what is the standard of care for the treatment of chronic pain?
A. Well, the standard of care is what would a reasonably prudent physician do under the same or similar circumstances.
Q. Can you expound on that?
A. Well, certainly. I think if we're talking about, I think to be more specific with this case, we're talking about individualized patient assessment is critical to the standard of care, particularly with the practice of pain management.

No two patients are the same. And importantly when we're talking about medications, no two patients will respond in the same way to a given medication, and they may have different outcomes. They may have different side effects.

And so I think the practice of pain management is one where individual patient assessment is really paramount to effective treatment. And that I think is really the basis of the standard of care here when we're taking about the practice of pain management.

THE COURT: Doctor, can I ask you to slide in a little closer to that microphone, please.

THE WITNESS: Yes.

Q. And that term I think you just mentioned twice, "individualized assessment," did you make that up?
A. No. I mean this is generally what we speak about in pain management. As early as my training I can remember speaking about individual patient assessment being critical, even as far

back as medical school.

Q. Can you tell me, sir, does -- I think you mentioned it, but let's pretend we have two patients that suffer from the same basic diagnoses, are you going to prescribe the same treatment plan for those two patients?

A. No. And again it comes back to individual patient parameters. So as we all age, we all develop different medical comorbidities or medical conditions.

On top of that, we may have different medications that we're already taking that may be contraindications to certain prescribed medications. So two patients may have the same pain problem; for instance, but have very different underlying let's say substrate, which would be important in determining what medication to pursue.

So they may have medical comorbidities that would preclude certain medications. They may also have medications that they're taking which would have drug-drug interactions. And then on top of that, there is an area of medicine called pharmacogenetics where just genetic, we're all different genetically. We metabolize and respond to medications differently, so you simply cannot treat every patient the same just based on the type of pain condition they're presenting with

Q. And could a treatment that worked for a patient in any given year, would that always work for that patient in every

instance?

A. No. I think things -- it's dynamic. It's a dynamic process, and that's why follow-up visits, regular checkup visits are important in my specialty.

In particular, people can develop tolerance to certain medications where certain doses are no longer effective, and we do need to titrate the medication or increase the dose to respond to that tolerance.

In other instances, patients may over time develop other medical conditions that would -- for instance, a very common one is kidney failure or kidney disease that would prevent the metabolism of the medication and potentially could be harmful if you maintained them on the same dose or if you continue that same medication.

And just to kind of bring it back in a more succinct manner -- and I don't mean to be so long-winded. My point is, pain management is an area where it is critical to look at the patients at individuals for the reasons I outlined; otherwise you're going to end up with ineffective care, and at worst potentially harmful care.

Q. What about documentation of a patient's medical history, where does that lie within the standard of care?

A. Yes. I mean certainly I would say right next in line after individualized assessment and documentation is critical. Not only for your own knowledge about the patient, but if the

patient should be seen by another provider or out-of-state provider or be transferred to a facility or a hospital, if your documentation is poor, the next person treating the patient is going to be at a significant disadvantage for treating the patient appropriately and potentially at risk for harmful treatment simply because they didn't know the critical elements of that patient's history.

And so documentation is really the essential ingredient in the standard of care because without it, you're operating in a vacuum and that is potentially harmful.

Q. And did you find anything about the documentation of the medical history of these patients that you believed deviated from the standard of care?

A. Well, yes. I think there was a number of issues with regards to the documentation. I think importantly a lot of their record is just handwritten notes, and I think we can all understand the nature of handwritten notes that could potentially lead to confusion, illegibility. Someone, the next person, may not understand what was written there. Paper charts can be lot, pages can be missing. So I think that's one issue, is the nature of a handwritten note is prone to error.

On top of that is, in this case, what I noted as a sort of unfortunate theme is that some of these claimants would rotate from one facility to the next for whatever reason. They would be transferred from facility A to facility B.

And when they got to facility B, either some or none of the medical record would go with the patient. And so the next provider in line would, as I mentioned earlier, would be starting from scratch again, where they don't know the history. They don't know the diagnoses, importantly they don't know what medications or doses that the patient was on; or that importantly, again in this case, what had been tried and failed before.

And so it really just created a nostrum f confusion, and I think led to those issues that I outline in the report.

MR. NOLAN: Your Honor, I just want to preserve an objection for the record. To the extent that Dr. Carinci is testifying to anything outside the scope of his report, we would move to strike that. I believe some of what he just said about the transfers was not in his report, but I'm not going to make him go through it now.

MS. AGNEW: We are discussing the documentation section of his report, your Honor. And sitting here right now, I don't know if it talks about the transfers, but I could certainly discuss that more in depth with Dr. Carinci because appended to his report were 25,000 pages of medical records.

THE COURT: I'm not sure what you're asking me to do at this moment, Mr. Nolan.

MR. NOLAN: I guess it would be reasonable to preclude any testimony that goes outside the scope of his report.

THE COURT: I'm not sure that this does.

MR. NOLAN: There's nothing in this report that I can see that talks about transfers from one medical facility to another, and he just talked about that.

THE COURT: My recollection -- and I don't purport to have memorized all of this, but my recollection is that some of the individuals who are discussed in the report did speak about transfers from one facility to another.

MR. NOLAN: Right. But this report is dated March 5, 2022, and the individuals who talked about transports weren't talking about the time period before March 5, 2022, that we know of.

THE COURT: I'm not sure it has to be a transport that was discussed in the report or was at the time. I believe the testimony the doctor just gave was generalized testimony applicable to most situations.

MR. NOLAN: Again, it's outside the scope of his report. If he's going to give --

THE COURT: Are you moving to strike it or not?

MR. NOLAN: Yes.

THE COURT: Denied.

MR. NOLAN: Thanks.

BY MS. AGNEW:

Q. Dr. Carinci, so beyond the medical records when we talk about the standard of care, what about the assessment of the

patient itself as recorded in medical records?

A. Yes. Assessment goes back to documenting subjective and objective findings. And again when we're talking about an evaluation of the patient, we're talking about an in-person examination with a -- again to be specific with our are of specialty here, a musculoskeletal and neurological examination.

On top of that when we're talking about the practice of pain management and understanding, is a medication effective for someone, we want to be able to document what they're pain score is, what their function is, any side effects. We want to be able to talk about the location of the pain, exacerbating or relieving factors.

And all of these things are -- they're sort of interrelated. There's the individual assessment, and then there's the documentation piece. And then there's an actual medical record that consistent and moves forward in time with the patient as not having to be recreated at each visit. All of these are interrelated in terms of the standard of care in actually examining the patient.

If you were going to be examined by a physician, you would want the same level of rigor that you're not having to recreate the same story over and over again.

Q. And what was your general impression reviewing the medical records that you studied of the quality of the assessments as reflected in the records?

A. Generally the assessments I would say were poor.
Q. And why is that, sir?
A. They were often very superficial. They often did not integrate the subjective and objective findings. There was no evidence that there often times was any sort of physical exam performed to corroborate the subjective and objective complaints.

And for those reasons, I would consider that to be a poor assessment.

Q. Let's talk about in the standard of care for the treatment of patients with chronic pain management issues, the importance or irrelevance of substance abuse history?
A. Certainly that's an important factor. The human condition, people will unfortunately abuse anything really that they can get their hands on sometimes.

And so knowing that there are certain medications that have a predisposition to abuse is important. Also consistent with that is knowing the patient's history, did they have a personal history of abuse of substances, whether illicit or prescription; is there a family history. Those are risk factors. Because ultimately, again, we don't want to create another problem on top of trying to solve one problem, which is pain, and then create another problem which is fueling and addiction process. So absolutely we would want to know that. It is important.

On the other hand, a remote history of abuse is not an absolute contraindication to prescribing medications with abuse potential. And people with a history of abuse are routinely prescribed medications with abuse potential, and I do that in my own practice. I think importantly though, there's a level of monitoring that may need to be more aggressive in those instances. Where, like in the outpatient world, for instance, we may not want to give a month prescription at a time.

We may see them more closely, perhaps every week or every two weeks while we're titrating the medication to ensure that, again, the patient is staying compliant on the regimen; that there's no issues. That, again, we're not creating harm.

Just to be more succinct on this, yes, it's a very important parameter when we are considering prescribing a medication with abuse potential, but it is not an absolute contraindication to doing so.

Q. And you used the term "remote," and I just want to ask you, is there some kind of bright line about how remote a substance abuse history has to be, how close in time where it becomes preclusive?

A. Well, let me say this -- and I'm not someone who prescribes like substances with abuse potential for someone who has an active addiction process.

If I knew that the patient in front of me had an active addiction to opioids, I think it would be very

problematic and really concerning to provide ongoing opioids to that patient. But an active addiction is very different than a history of remote addiction. And remote really can be anything other than an ongoing active addiction.

So, yes, once you have a history of addiction, you're always at risk for potentially doing it again; but with close monitoring and supervision, many of these patients can consistently stay on these medications in a safe manner.

Q. I want to ask you are about -- you are a specialist, correct, sir?

A. Yes.

Q. And you provide what we would call general medical care to patients, like my family practitioner?

A. No.

Q. When you looked through these records, could you tell the Court what you perceive to be the role of this specialist?

A. Well, the specialist's job is to often times answer a very specific question about a subset of the patient's medical history.

So, for instance, I'll just be specific with my specialty. I receive referrals from both primary care doctors like you're referring to, and from other specialists outside of my area of specialty, so say an orthopedic surgeon.

And the request is generally very specific. It may come in for a specific body part, a specific pain condition, or

even a specific question with regards to a medication. But a referral is made with the understanding that if I'm sending out a referral, I'm asking for help. I'm not sending someone to you because I don't want to take care of the patient anymore. I'm sending them to the specialist because I need assistance.

I'm asking either a particular question, or I'm asking for assistance in a particular condition. And so the role of the specialist is to provide a very focused answer to a request or problem, as opposed to a general practitioner who may be dealing with five or ten different issues on a more superficial level. The specialist is going to delve deep into the specifics of a particular issue.

Q. When you review the records of the patients that you talk about in your study, did you find that their appointments with specialists mimicked your own experience?

A. I think it mimicked it in terms of providing -- what I do is, I examine the patient, and I provide a succinct answer about the condition.

So if the questions is, is X, Y and Z medication appropriate, I would provide a specific answer for that. If the question is, Can you provide some guidance on the management of this patient's diabetic peripheral neuropathy, we'll provide an answer there. So the role of the specialist is to provide the answer. And I did note that the specialist consultations were fairly succinct and provided an answer.

Q. And did you find that those specialty consultations were generally followed by the practitioners back in the facilities?
A. Generally followed, no. I think in most instances there was confusion.

And I think it's important to understand who was following them. It seem like the front-line providers were trying to follow them. And the front-line provider would be the person who filled out the MWAP request form. I'm using a generic term "front-line provide." I don't know if they're refer to as primary doctors or front-line doctors, but the person who is filling out the MWAP request form would often try to follow the recommendation.

So, for instance, if the recommendation was restart gabapentin, the front-line provider would fill out the MWAP request form with the requested gabapentin following specialist recommendation.

When it got to the level of the regional medical director, there was just a systematic issue there where that regional medical director, first off, didn't have access to the specialist recommendation. I think broadly speaking they didn't have access to the patient's chart even. They definitely didn't have access to the patient. And they were really making these decisions in a vacuum unfortunately without the critical necessary information to be able to determine, is it indicated or not.

So to answer your question, no, they weren't being followed by the regional medical directors in general.

Q. Let's now turn, sir, to the conclusions in your report, start on page 42 of the expert report. And I'd like to walk through those. Let's talk about the MWAP policy itself. Did you review that?

A. Yes.

Q. Did you find that the MWAP policy itself followed the standard of care?

A. I don't have an issue from a standard of care perspective with the MWAP policy. I don't agree with it in its entirety. We can delve into that, but, no, I don't think the policy itself was below the standard of care.

Q. Why don't you tell me what your disagreements were with the policy as written or your concerns?

A. I think the policy overstepped the potential or the potential abuse liability of certain medications that were within the policy, and it sort of lumped all of them in a large bucket where there's varying degrees of abuse liability.

For instance, there's many medications in there including some of these culprits that came up again and again in this particular litigation with regards to gabapentin and Lyrica where the abuse liability of the medications is exceedingly low, and really based on a lot of different factors.

And I think that's where I think this policy sort of went astray where it oversold the abuse liability of some of the medications that were within the policy and essentially prevented people from getting them.

Q. Let me ask you, cause they're going to, are you an expert in correctional healthcare?

A. No.

Q. Have you ever heard of the certification in correctional healthcare?

A. I have not heard that.

Q. Do you believe sitting here today that there is a specialty where someone could be board certificated in correctional healthcare?

A. I have not heard of it.

Q. When you talk about these culprits, and I think you mentioned gabapentin and Lyrica, could you talk to me about some of the things you found that would -- strike that.

Did you see any evidence of how those two drugs in these kind of -- this family of drugs were administered in the prison environment that made you feel better about their administration?

A. I think, yes. My understanding, particularly let's say gabapentin for instance, is in liquid form and is administered as a unit dose when the patient presents for the medication. That is in vast contradistinction to say the community where

when I provide gabapentin to a patient, they go to the pharmacy and they receive -- it's many times it's a jar of 180 or 360 tablets of gabapentin all at once.

And so I think one scenario is very different from another. If someone is given a jar of gabapentin and you're concerned about the abuse liability or you have concerns about the patient, that's a very challenging situation to present a patient with 360 tablets of a medication, versus they present to a window. They're monitored. They take a liquid dose. There's really no opportunity to abuse that medication. They can't take it with anybody other concurrent agents for like a sort of sedative or synergistic effect. So I think, yes. Does that answer your question?

Q. It starts to. Would your conclusion be that the administration of these medications is much more controlled in a prison environment than it is, per se, one of your patients?

A. Yes, absolutely. That's what I neglected to say. Yes. The aspect of the prison environment where the patient presents for a unit dose of liquid gabapentin is a much more reassuring process than a patient in the outpatient world going back to their apartment or home with 360 tablets of gabapentin.

Q. Would you as the treating physician know if your patient then went and abused that large bottle of gabapentin?

A. I mean, you may or may not know that, right.

If the patient comes back requesting -- that

prescription was supposed to last them a month, and they come back in a week and say they need more or they're requesting higher doses or they're presenting in a very sedated format or urine screen comes back showing a very high dose of gabapentin in their system, those are concerns.

I will say -- and I've testified to this before -- is that in my 15 years of practice, I have not had a patient that I've been concerned about was abusing gabapentin. I've not had anyone ask me for more gabapentin that I provided. I've not had a scenario where somebody ask me to very early on refill a dose that should have lasted them a month.

I have not had anyone with a failed urine screen for gabapentin or concerns for selling it or a family member reporting that they're overtaking it. So, again, this is just my 15 years of practice with gabapentin which has been around for a very long time not having concerns about it.

Q. And have you had concerns about other medications within your practice being abused by your patients?

A. Yes, certainly.

Q. Can you just explain a little bit of that to the Court?

A. Well, I think opioids are the main issue in my specialty. And it's been -- it's a scenario of like a pendulum where in the '90s, maybe the early 2000s opioids were more liberally prescribed.

Now we're on a different scenario where opioids are

much more tightly controlled by primary doctors and specialists and the like. And opioids have a very well-known very well defined liability, abuse liability, a liking ring forcing addiction sort of process.

And I think this sort of draws back to my earlier statements with regard to the MWAP policy sort of lumping all of these types of agents together is problematic. So, yes, opioids are definitely abused. People do ask for early refills. People do take more than prescribed. In my 15 years of practice, I've had instances of people abusing them, taking more than prescribed. All of those various infractions. Having to discontinue patients from taking opioids, sending people to rehabilitation because of opioid abuse. I mean these are all real phenomenon. In contrast, I have not had any of that with gabapentin.

Q. What about Lyrica?

A. I have not had that with Lyrica.

Q. Let's now move from the facial policy itself. What were your conclusions about how MWAP was implemented at least throughout the records of the 70 patients that you reviewed?

A. I think the big issue here is that how the MWAP was implemented was done in a very broad stroke manner that was non-individualized. So it was applied to patients in a manner that did not take into account their individual picture parameters.

So just bluntly, people were discontinued on their medications without an individualized assessment. And so the policy itself was implemented in a manner inconsistent with the standard of care that we talked about earlier because there was no individual patient specifics.

And really it's very clear when you look at how those medications would be approved in this process because it was the regional medical directors who essentially had the power so to speak to give the thumbs up or thumbs down on these medications, to say yes or no, and they simply didn't have the ability to make an individualized assessment.

They didn't evaluate the patients. They had very basic information about the patient. They had no access to the patient's chart. And so for those reasons, it's not conceivable that these were individualized assessments. These were very non-individualized. It was implemented in a non-individualize manner.

Q. Dr. Carinci, didn't the MWAP form that you reviewed as part of your process and the compilation put together by my office, wasn't there enough information on that MWAP form to make a study considered decision based on the standard of care?

A. No.

Q. Why do you say that?

A. Because those forms lacked the information needed to make the determination in an individualized manner.

For instance, with regards to specialist recommendations, with regards to medications that had been tried and failed, with regard to the efficacy. On hindsight, those forms, those request forms, did not encompass that data.

Q. Let's talk about, within that you come to a conclusion about the oversight of the regional medical directors and the administrators over this MWAP implementation. Can you speak to that?

A. Yes. It was a very haphazard confusing and chaotic implementation and oversight. I think, for instance, on one hand those first-line providers were provided literature, articles and other forms of sort of "educational material" with regards to these medications with abuse liability, such as gabapentin and Lyrica; and what indications they would be useful for and how to dose them and how to monitor them. They'd be provided that information about how to utilize them.

But on the other hand, the actual use of these medications was to the point where they were refused so often that these front-line providers basically stopped asking for them. So they would repeatedly ask for them. They would be repeatedly denied, and it sort of left those front-line providers sort of cycling back to the same three medications that had been tried and failed over and over again. And that would have been Ibuprofen, Elavil or amitriptyline and Cymbalta.

So the oversight of this process was really just very poor, not only was implementation, but also the ongoing oversight of the process was chaotic and problematic.

Q. Did you see any evidence in the medical records you reviewed that RMDs would then follow-up about the patient's effective treatment after an MWAP was discontinued or denied?

A. No, I didn't see that.

Q. And you just talked about I think cycling through alternative medications, can you expand on that for the Court?

A. Yes. So in lieu of a utilizing an MWAP medication, it was understood that there were basically these three medications that could be utilized without any degree of MWAP request form.

So you didn't have to request someone's authorization. You didn't have to request the regional medical director's input If you wanted to use Ibuprofen, amitriptyline or cymbalta. So you would see again and again these attempts to utilize those medications, those three medications as I mentioned, when they had been tried and failed before. Even when there was contraindications to utilizing those medications. And so, yeah, it was just very problematic in that sense.

Q. What does it mean for a drug to fail?

A. Well, a drug failure could take a number of different meanings. One with regards to pain management would mean they didn't provide efficacy. There was no analgesic or pain

relieving response with it. They were titrated up. It didn't help. It was a failure. It didn't help the problem.

Another form of failure is intolerable side effects. They were titrated up to a therapeutic dose, but it wasn't able to be taken due to intolerance of side effects. That could be nausea, could be dizziness, could take on a number of different areas. That would mean failure.

I think also I would look at failure in a broader sense also saying that if, you know, it's a contraindication to utilize that medication, that's sort of also like a dead-end. It's a failure. Going down that route would be a failure. for instance if there's a drug-drug interaction with using that medication or the patient has an underlying medical problem that would preclude you from utilizing it then that would be a failure to me. It takes one of those three forms.

Q. And you have a section in your conclusions at page 43 where you talk about lack of knowledge about medications hurt patients.

Where do you see evidence of that lack of knowledge, and who in your conclusions lack the knowledge?

A. Well, the lack of knowledge sort of stem from seeing patients that were reporting ongoing constipation, for instance, horrible constipation that required multiple medications to alleviate; or horrible urinary retention that required catheterization to alleviate the urine.

And you would look back and realize that those patients in some instances were actually being prescribed Elavil which is a tricyclic antidepressant medication that was one that was often posited as being, don't use an MWAP. Use this. Unfortunately that medication is prone to having those particular side effects. It's very prone to it.

And when you also have a patient who may be prone to those potential issues due to underlying medical condition, starting them on Elavil for instance would only worsen or precipitate or exacerbate those underlying problems. So there were instances where the patient would continually have to self-catheterize to get the urine out, but they were also repeatedly going up on the dose of Elavil.

So it was clear to me that that provider just didn't understand that Elavil was a tricyclic antidepressant that was going to cause this. I think that goes back to the oversight in education part of this where they were repeatedly told to use that and then you create an issue. So that was one of the main issues that I saw there.

Similarly, things like cymbalta being prescribed to people that were already on -- so cymbalta is a -- it is an antidepressant medication. And in many instances patients were being put on cymbalta when they were already on an antidepressant for anxiety or depression. And they were being told, let's put you on cymbalta for pain, when that would

really be an inappropriate thing to do because you could create this drug-drug interaction with two antidepressants that are going to precipitate either depression, could precipitate mania. And again just not being monitored or really understanding the potential downstream effects of those medications.

Q. So let's talk about one of your culprits as you call it gabapentin and what conclusion you came about regarding the impact of gabapentin by the implementation of the MWAP policy?

A. So in many, many instances as I've outlined in my report here through the 70 patients, the gabapentin was discontinued without for non-medical records and without regard to the individual patient parameters.

So you see many instances where patients were stable on gabapentin for many years leading up to the institution of MWAP. They were taking the medication. They were functional. They had good analgesia. And really sort of without any medical indication, the medications were titrated off, discontinued, tapered down, substituted with amitriptyline or some other medication like cymbalta without any medical rationale and for non-medical reasons, and irrespective of their individual patient parameters for use.

It's like we talked about, everyone responds differently to these medications. And if you're lucky enough to find a medication that does work for someone, it's really a

critical decision to discontinue that medication. You've got to have a good reason because people could try for years to find an effective medication. And so really, the decision to taper off an effective medication is not to be taken lightly. There's got to be an impetus to do so, a medical impetus really, whether that's the patient developed a medical condition that the medication is no longer safe for them.

They're on another medication like a chemotherapy agent or something that's going to interact with the drug, and so they need to be tapered off, and those are just particular instances.

But my point is that in this case gabapentin was a very common culprit here that was tapered off for non-medical reasons, for no medical rationale was provided for why, and really irrespective of the individual parameters of efficacy and functional improvement on the agent.

Q. In your expert opinion would just the potential abuse potential of a drug. Sorry. I just did that twice.

Would the abuse potential of a drug be a medical basis absent other factors for discontinuing it?

A. No.

Q. Talk to me a little bit about that, like what is the spectrum?

You touched on it, why would you just stop effective treatment for a medical basis?

A. Well, for a medical bases, a perfect example is, someone is on gabapentin. They're doing well with it. A medical reason to discontinue would be they developed kidney failure. And because gabapentin is metabolized through the kidneys. If your kidneys are not working, you're going to accumulate massive amounts of gabapentin and you're going to essentially be highly sedated and potentially worse off.

So in those instances, we need to move to a medication that is not metabolized through the kidney. We may need to pursue some other route, but it wouldn't be gabapentin. So that would be a medical reason to discontinue it, even though it was effective.

Q. What about Lyrica?

A. Same thing. Lyrica and gabapentin, they operate at the same receptor. Lyrica is a newer formulation of gabapentin that's -- just to be simplistic with it, it's just a more potent version of gabapentin. You can titrate people to a higher dose quicker with less side effects, but the same provisos with gabapentin would be applicable to Lyrica.

Q. And in your experience as an expert in pain management are there patients for whom gabapentin or Lyrica alternatively work better for that particular patient?

A. Yes.

Q. And so how would you as the medical provider come to that conclusion?

A. Well, generally speaking we would start someone on gabapentin first because it's generic. It's been around longer. Most people's health insurance would want them to try gabapentin before Lyrica. And it just makes sense because gabapentin is generally well-tolerated by many. So we'll start there.

We'll titrate people to an efficacious dose. Hopefully we can get them there. If we reach either the maximum dose without any benefit, or we get to a dose that is not providing benefit or is having intolerant side effects, then we would consider Lyrica. It's hard to know, maybe 30 percent of people will have efficacy with Lyrica versus gabapentin.

Q. One of the other conclusions you touch on in your report regards baclofen and muscle relaxants. Can you explain that particular conclusion to the Court?

A. Yes. So baclofen is a medication that's used for myofascial muscle spasms, muscle related pain. It's an antispasmodic agent, but is not without harm.

Baclofen was also reverted to as the muscle relaxant of choice. Again, even when it had been tried and failed, even when there were reasons, medical reasons not to use it, when there are many other muscle relaxants that are equally or in some cases more efficacious with more side effects.

So the general sense in reviewing these records is

there was just this overprescription of baclofen when it wasn't necessary to do so, and when there was even reasons not to do it.

Q. And what would the alternatives to baclofen be in your practice?

A. There is many other muscle relaxants to use. Some of them are old. Some of them are new. Flexeril is one. Zanaflex, Robaxin is another. Those are the main ones that we can consider using.

And, in fact, I think most providers would reserve baclofen later down the line after one of those other failed because baclofen is so heavily sedating. And also once you're on baclofen, you can't discontinue it abruptly. It has to be tapered down. And that was again going back to the oversight monitoring education part of this, you often saw the medication just being tapered abruptly, not really understanding that it is a medication where people could actually have a withdrawal from it.

Q. In your experience though do these alternatives Flexeril, Robaxin, forgive me for forgetting the other one, do those have abuse potential?

A. No.

Q. None whatsoever?

A. Not to my knowledge, no.

Q. Have you ever had a patient in 15 years abusing Flexeril?

A. No.

Q. So now I want to talk to you about what you call in your expert report the reassessment process.

First, to your knowledge, can you tell us how that came to be?

A. Well, the reassessment process really was something that came to be as a means to mitigate the effects from the implementation, the poor implementation of the MWAP where many patients were discontinued off their medications in this sort of broad-sweeping non-individualized, non-medical manner.

The reassessment process was meant to sort of solve the ills of that process. In other words, could we actually sit down, reassess the patient, determine if there was a medication they were functional with; and was there a reason to discontinue it. And if not, can we consider reinstituting it, or is there some other measure we can take here. So basically to see if we can mend the wounds from the poor implementation of MWAP.

Q. And did you have any role in that reassessment process?

A. Yes. Early on we met with some of the DOCCS I think medical team in sort of putting together what we would consider a reasonable reassessment process; how would we think about reassessing; what are the components; and how should we do it.

And I was involved -- I think it was a zoom call if I'm not mistaken -- with several participants with DOCCS.

Q. Can you tell me -- and those are not in your report, did you design any documents to kind of guide that reassessment process?

A. Yes, we had a -- it was a reassessment form I think we called it.

Q. Would it refresh your recollection if we call those treatment algorithms?

A. Yes.

Q. To your knowledge when you reviewed the records, were those treatment algorithms used by the providers when they did these reassessments?

A. Sometimes.

Q. So now I want to talk about your review of those reassessments and what you found.

First, why don't you just explain to the Court what we had hoped? What you had hoped and us as well would happen in a reassessment?

A. So the reassessment was really designed to answer a very specific question, and this really was, Was the patient on a medication that was helpful; and was there a reason that that medication was discontinued.

In other words, we wanted to refresh on the idea of, like, where this patient is in time, relative to where they previously were prior to the institution of the MWAP.

So, for instance, we would ask question -- that form

that you're talking about was really designed to guide the practitioner in answering that question in a way that was reproducible and was understandable for someone else who read it.

And if at the end it was clear that the medication was discontinued for a medical reason that was particular to their individual circumstance, well then so be it, great. Let's move on to the next person.

If on the other hand at the end of that analysis we determine that there really wasn't a medical reason that this medication was discontinued, there was really no individual patient parameters that guided the discontinuation of that medication, well then perhaps we can consider reinstituting it. So that was really the point of the reassessment process was to answer that question.

Q. To your knowledge was there only one sweep of reassessments?

A. No, there was some of two waves of reassessment, July of 2020 and then it was sort of November fall of 2020.

Q. And to your knowledge were the reassessment forms in that process used for both of those sweeps of reassessments?

A. No, it was used in the second.

Q. So talk to me about the first to your knowledge and what you saw in the records?

A. Well, I would say the first wave of reassessments was just

fraught with problem right from the start. It doesn't seem like the front-line providers who were performing those reassessment really understood what the point of the reassessment was.

Often times in the documentation there would be various notations of data that were collected that were off base relative to the question we're trying to answer here. So there may be multiple documentation about lung studies and pulmonary function test and lung medications, and no mention at all of the gabapentin or the specialist recommendations or even the pain of the patient. So it was clear that when you read that reassessment it was clear when the person who did it just didn't understand what they were being asked to do.

They just thought they're going in there to assess the patient in a broad sense, like as a medical provider. I'm going to address your multiple medical problems, opposed to reassessment to the MWAP medication. And so that first wave of reassessments was really just problematic for those reasons. It was off-base. It didn't answer the question. Many times it didn't mention pain medication. There was often not an exam performed. So those were the issue.

Q. What about that second wave where we had the form, what were your findings when you reviewed those documents?

A. The second wave I think was an improvement over the first, but mostly because we provided a form that was to be filled

out, so that at least guided folks. But again I think the education on what that form was designed to do and what question we were trying to answer was again just off-base.

It was not a context sensitive evaluation. In other words, the context being the MWAP policy and the institution of the policy and the medications and pain management treatment thereof, that was the context of why the form was being done. But the forms were completed in a manner that was context insensitive. Like they didn't recognize that, hey, in this particular instance with this particular patient, it's all about gabapentin.

The patient was on gabapentin. They were very functional on it for such and such reasons. Here's the objective data with regards to their subjective complaints, so here's some X-ray findings. Here are some MRIs findings. Here's a list of medications that they failed before and why they failed them. Here's an examination of the patient. They have weakness in the leg. They can't bend over, whatever it is, musculoskeletal neurologic.

There's really no contraindication to restarting gabapentin. The patient was functional on it, no side effects, doesn't have an abuse history, never abused gabapentin or anything else. Let's consider reinstituting gabapentin. I know I'm sort of just glazing over the points, but that's what we were sort of looking for a context sensitive evaluation that

answers the question.

Even with the use of that form it was just again a somewhat chaotic analysis where elements of the histories were missing. Elements of the medications that were really critical to this whole process were missing, so it was hard to know where the disconnect was, but there was clearly a disconnect.

Q. And why as a part of that process is the history of failed medications important?

A. Well, for the reasons we outlined earlier. These medications are not immediately effective. Many times the agents we're talking about take many, several months really to get up to efficacious level.

So when you got someone who has diabetic peripheral neuropathy and burning pain in their legs and they've been stable on gabapentin, the medication's discontinued. There's no reason why, but they're started on amitriptyline, but we've already documented that amitriptyline is a failure. As the provider, you're not going to recognize for probably another two or three months if the patient is actually willing to go down this road again. So you're essentially just wasting time. You're wasting the patient's time. You're wasting your time going down a road that's already proven to be problematic when you've already got an answer that is effective.

If you don't have a reason to discontinue that medication as we discussed earlier, you're basically causing

harm.

Q. What about the physical evaluations of patients on those reassessments?

A. For the points we touched on earlier, the physical evaluation is critical because the job as the clinician is to corroborate the subjective complaints with the objective findings. And those objective findings come from the studies, whether that's an MRI, an X-ray, an EMG what have you, and the physical exam.

Because we're not just taking the patient's subjective statements as a hundred percent fact without any corroborative data, we're trying to integrate that, all of those data points to come to a conclusion about the overall plan, assessment and plan. And so without a physical exam, a documented physical exam, you're basically only having a small portion of the history of the subjective complaints available to you.

Q. Did you see good evidence within those reassessments of physical evaluation?

A. Not routinely, no.

Q. Tell me something, the objective of those reevaluations, was it just to put every patient back on an MWAP?

A. No.

Q. What was the objective?

A. As I said earlier, the objective was the context what we're talking about. It was to answer the question. Was the patient

on an MWAP medication that was effective, and was it discontinued for a non-medical reason and for non-individualized parameters.

If the answer was yes to that and there was an MWAP medication that we could identify that was effective, can we consider reinstituting it; or is there a reason we can't. So it wasn't that everybody needs gabapentin, that was not the point of the reassessment period.

The reassessment period was the context of the MWAP implementation, and we really wanted to answer the question as I outlined earlier, were they on a medication that was effective for them, and why was it discontinued. Is there a medical reason or not and go from there, a path forward really.

THE COURT: Could I just ask a question, were the reassessment done after the MWAP policy was withdrawn and at or about the time when policy 1.24A was promulgated?

MS. AGNEW: No, ma'am. So the second swath of reassessments took place around November of 2020. That's bourne out by the documents. DOCCS rescinded MWAP February 3, 2021. Somebody can correct me -- 8th. February 8th of 2021.

THE COURT: Thank you.

BY MS. AGNEW:

Q. Tell me this, when we're talking about the objective of these reassessments, was the objective perfect analgesia? I'm saying that wrong. You just gave me a look --

A. No. No.
Q. Was the objective to completely cure the patient's chronic pain? Is that the objective?
A. No, and it never is in the process of pain management. It's impossible to get perfect. You can't get the pain score to zero.

And importantly here, there maybe instances where an MWAP medication was not medically necessary or reasonable. It wasn't about, again, everybody that step forward is a candidate for MWAP and should be on it; but with a proper analysis and a proper reassessment, we'd be able to answer that question in a reproducible rigorous manner that was individualized.
Q. So tell me, sir, we created these data subsets which are appended to your report --

MS. AGNEW: And, your Honor, Mr. Manly has three small binders to his right. You might want to pass those up, and we do apologize for the presentation. Your Honor, this report was so big and huge, we've done our best.
Q. So I do want to talk about those exhibits, Dr. Carinci, first I want to turn your attention to Exhibit 70. And again, I know you touched on it briefly, but talk about how you looked at the data from these 10,000 MWAP request forms?

MR. NOLAN: Real quick, is it P128?

MS. AGNEW: Yes. So 70 has been premarked, your Honor, P128.

THE COURT: Yes, ma'am.

MS. AGNEW: I'm going to approach the witness and make sure he has it.

Q. Dr. Carinci, Exhibit 70, was that one of the sources of evidence you used?

A. Yes.

Q. And to your knowledge, where did that data come from?

A. This data came from the MWAP forms themselves.

Q. Did you review the MWAP forms themselves in their entirety?

A. Well, there was like 10,000 of these forms, so I wasn't able to personally review each and every one of those forms, but I had asked -- understanding that time was of an essence here, if your office could put together a more condensed version of those, pulling out the salient data and putting it in a manner that I could read through it and understand the themes, why they were denied, what was approved, what wasn't and why.

Q. Is it your understanding when we pulled together this data that it was pulled directly from the MWAP request forms themselves?

A. Yes.

Q. Did you have an opportunity to spot check, but did you have an opportunity to peruse through the MWAP request forms themselves and kind of do a spot check against what we produced to you?

A. Yes.

Q. Were they perfect?

A. No.

Q. Given that they weren't perfect, how did you use them recognizing there might be some imperfection?

A. I looked for themes, understanding that, look, again, we're talking about 10,000 of these forms, I wanted to get a sense for broadly speaking how many were approved, how many were denied, how long were they approved for, kind of just getting a 10,000-foot view.

Just like when I talked about with the patient records, a starting point for digesting the material. It's just impractical to delve into each and every of those 10,000 MWAP review forms and start taking my own notes on them. And so the synthesis of this information as put together here in Exhibit 70 was a means to digest that information in a more efficient manner.

MS. AGNEW: Your Honor, I would like to move into evidence Exhibit 70. It's Dr. Carinci's report. We premarked it P128. We would like to do that as a 1006 exhibit, and we did bring all of the underlying records which are in binders behind if my colleagues wanted to review them or test the data.

MR. NOLAN: Your Honor, we object to the introduction of this exhibit into evidence because it doesn't meet the requirements of FRE1006.

In this Circuit in order for a summary chart or summary of evidence, particularly one created by counsel, the offering party has to establish a foundation connecting the numbers in the chart with the underlying evidence for the data on the chart. And the Court must ascertain that the summary charts fairly represent and summarize the evidence upon which they are based.

There has to be foundation testimony connecting it to the understanding evidence summarize. We haven't heard a foundation evidence who prepared these testify today.

THE COURT: Counsel.

MS. AGNEW: Your Honor, it's not our position that we have to provide the actual person, but that he needs to authenticate them, that they're admissible. And I would point to the Court's order of March 1st of 2021 where we talked about the admissibility of the underlying MWAP request forms. Cause if the Court recalls, they were all produced to us in Excel spreadsheets. You couldn't get to the data.

We then went ahead and converted them, and we had to move for an order allowing their admission because state defendants were concerned that we had played with data, which of course we had not.

My understanding of 1006 is that Dr. Carinci having spot-checked the data, which of course nobody could go through 10,000 forms and confirming its reliability and the fact that

it reflects what is on a spot check of the forms is a witness who can lay the foundation, and then through which we can bring in the summary.

THE COURT: May I see the prior order you preferred to, please?

MS. AGNEW: Yes.

THE COURT: And is this document, Plaintiff's Exhibit 70, or Plaintiff's 128, is that the MWAP forms in the PDF format that is referred to in the March 1, 2021, order?

MS. AGNEW: It is, your Honor those exact forms are laid out here in about 25 binders.

THE COURT: Mr. Nolan.

MR. NOLAN: We have no objection to the MWAP forms being in evidence, your Honor. It's the chart itself. We just don't have any foundation. We don't even know who specifically created it.

THE COURT: Can I hand you back the order that was just handed to me, please.

MS. AGNEW: I can give him a copy.

THE COURT: Please do. Isn't this already ruled on?

MS. AGNEW: To be fair to Mr. Nolan, this does predate his entrance into the case.

MR. NOLAN: I'm not seeing where it says that these are admissible at trial.

THE COURT: Maybe read it. It talks about the

declaration from Mali Curran, C-U-R-R-A-N, at docket number 207, setting out the steps she took to convert the forms, that is the forms received from defendants, into a readable PDF format.

MR. NOLAN: I still don't know how that makes it admissible at trial. Somebody submits a declaration, for example, on a motion, it's still hearsay at trial.

THE COURT: Right.

MR. NOLAN: So we have no foundation testimony from Ms. Curran here. We have no ability to cross-examine Ms. Curran, or if that's who created it.

THE COURT: It seems to me that the declaration that is reflected in the March 1, 2021, order does that; and at the time, apparently the parties were fighting about whether or not to admit this document.

MS. AGNEW: No, no, your Honor. I want the record to be very clear. The fight among the parties was about the admissibility of the MWAP request forms themselves. If counsel wants us to admit all of those into the record, we're happy to do it instead of this summary.

He suggested that's okay with him. We can do that. Our expert of course could not go through all of those. We did have -- and there's a declaration on the record from Sterling Avellino. He is the one who extracted the data and created the summaries that Dr. Carinci relied upon.

Dr. Carinci then spot-checked the summary data in Exhibit 70 through 73 against the MWAP request forms to make himself feel comfortable that it was an accurate reflection, and he's laying the foundation that he then relied on that data. We could also call Mr. Avellino. He's at school, but I can get him on a video tomorrow and we can do this again. I'm happy to do that as well, or we can go ahead and admit all the MWAP request forms.

THE COURT: Would you hand up the Avellino declaration. I know we just had it recently, but I don't have it in front of me at this minute.

MS. AGNEW: Forgive me, your Honor, I did not print it out.

THE COURT: Tell me the docket number and we will pull it up.

MS. AGNEW: If we can go off the record for two minutes.

THE COURT: Do you want to take a break now? We've been going an hour and a half or so, is that a reasonable idea?

MS. AGNEW: That's great, your Honor. Thank you.

(Recess)

THE COURT: Have you had a chance to chat?

MS. AGNEW: We have not. I thought we were, so I'm going to renew my motion to admit into evidence Exhibit 70 of Dr. Carinci's report which we premarked P128. It is a summary,

although I'll state, if they have no objection to all the MWAP request forms themselves, we'll do that. I think the record on appeal is going to be painful, but we'll do it.

THE COURT: Let me ask you this question, what is the relationship between P128 or Exhibit 70, and the PDF format referenced in Ms. Curran's declaration versus the document referenced in Mr. Avellino's declaration?

MS. AGNEW: Sure. So the binders back here, which your Honor can't see. It's about 15 binders. Those contain the documents Ms. Curran created. Mr. Avellino then pulled the data from those documents to create the summaries that Dr. Carinci relied upon; because if I sent him that many documents, he would quit.

THE COURT: Mr. Nolan.

MR. NOLAN: Your Honor, with respect to Mr. Avellino who we understand I think was the author of Exhibit P128, he was subpoenaed to testify for a deposition. Your Honor, you quashed that subpoena, without a motion. The parties never got an opportunity.

THE COURT: I'm sorry. There were letters back and forth.

MR. NOLAN: There were letters back and forth, but there was no formal motion.

THE COURT: Let me say for the record, I took the letters as a motion and a opposition.

MR. NOLAN: Fair enough, but it was ordered and it was quashed. The parties never had the opportunity to depose Mr. Avellino, so we would object to him even testifying.

THE COURT: My recollection of that exchange was that, the question was what was the defect in the 1006 summary that was to be the subject of the deposition. And there having been none stated, there seemed to be no reason to order the deposition. And that was, by my recollection, the finding that was made.

If there is something else that counsel wants to examine about to cast doubt on the accuracy of the Rule 1006 summary, then by all means, let's hear it.

MR. NOLAN: Respectfully, your Honor, I think sort of the purpose of the exercise of deposing Mr. Avellino was to do just that, to understand exactly the process he went through to test his declaration, which would be standard in any discovery. It was quashed. And now we're being told his declaration is the foundation for his testimony. That declaration is hearsay. It's inadmissible. It cannot serve as the foundation. That's other objection.

MS. AGNEW: Your Honor, a couple of points. The first is that it was state defendants who served the subpoena on Mr. Avellino. It was not defendant Moores counsel, nor did they, as far as I know, join in any motion or submit any letter at all.

You are correct that it was about whether or not there was a defect in the 1006. I think you gave Mr. Ramage every opportunity on the record to enunciate those defects. He couldn't come up with any, but you did reserve his right to renew his subpoena should they come up with anyone. They didn't.

But again, your Honor, we are happy to admit the MWAP request forms. My only concern is about the record on appeal and how voluminous that will be, but I will tell you the plaintiff class would love to have those in the record. I think the utility would be better to have the summaries, but what your Honor decides we're going to be happy with.

MR. NOLAN: Separate issue of the MWAP request forms, your Honor, I don't think we've gotten there yet in terms of the testimony, was in fact brought to the Court's attention at docket number 684 when Ms. Agnew filed a submission about Dr. Hammer's deposition where Dr. Hammer pointed out the issue that the MWAP forms were not accurate.

MS. AGNEW: No, that's not what he said. Your Honor, just so the record is extremely clear, we created separate binders by RMD.

So at Dr. Hammer's deposition, we put two binders down in front of him that we believed to be Dr. Hammer's MWAP request forms. What we found out is just because the face of the form said Dr. Hammer, that doesn't mean he was the

reviewer. And in fact we were able then to identify Dr. Hammer's request forms based on his initials, which he would add to the end of his reviewer comments.

So the issue that arose in Dr. Hammer's deposition is we could not with precision identify the actual RMD reviewer of any given form. Dr. Carinci is not making a conclusion based on who the specific RMD reviewer is. He's making his conclusion based on the contents of the forms themselves and whether or not they were approved or disapproved.

THE COURT: So with respect to the Dr. Hammer dispute, would you refresh my recollection about whether the outcome of that was?

MS. AGNEW: So what we did, your Honor, was we reopened discovery so that state defendants could reproduce the MWAP request forms to us based on the RMD's computer they came from. So each RMD, as I understand it, when they process an MWAP request form would save it on their personal desktop.

What happened is when the state defendants originally produced those MWAP request forms, they threw them altogether. They took the 10,000 forms from four different computers, threw them altogether and produced them to us. I think all counsel relied on the fact that the face of the form would say Dr. Mueller, Dr. Hammer, Dr. Dinello.

What we didn't appreciate is just because the provider put my RMD is Dr. Hammer, that didn't mean Dr. Hammer reviewed

it because he might have been on vacation. In which case, one of the other RMDs would step in and do the review and write the comments, so it was really a production issue. I'm not blaming state defendants, but at the time no one appreciated what was going on with the forms.

We then would, as we pulled the data, say this is a Dr. Mueller form based on the face of the form. When we sat down with Dr. Hammer he said, gosh, some of these aren't me. I wouldn't have written that.

THE COURT: I got it. So Mr. Nolan, I'm not certain what it is you're telling me about the Dr. Hammer situation that bears on this issue.

MR. NOLAN: I guess I would in summary say we don't necessarily believe there's any foundation for those. But if they're moving to enter them now, that's not clear to me, but if they are, I think the easiest way to deal with this if they're concern about the MWAP forms in the record, for them to produce Mr. Avellino to testify as to foundation on the Exhibit 128.

THE COURT: Why don't we do this then, we'll admit the underlying forms and permit Dr. Carinci to testify as to the documents subject to connection with Mr. Avellino.

MS. AGNEW: Your Honor, if we're admitting MWAP request forms, I don't need Mr. Avellino, right, because we're not entering the summaries.

THE COURT: To your point, we don't want to overburden our friends across the street on the 17th floor. Let's do it subject to Mr. Avellino's testimony, which hopefully can be videoed in at a convenient time, but this will allow the testimony to go forward this morning.

MS. AGNEW: Very good.

THE COURT: And if it turns out that the 1006 summary comes in, then you people don't have to burden the Court of Appeals with the MWAP forms.

MS. AGNEW: Your Honor, would I like to do is come back with some exhibit numbers with those.

THE COURT: Certainly. You let us know how you want to mark them.

MS. AGNEW: I will, and I'll come on the record a little later today because we have a little work to do then. Shall I proceed, your Honor?

THE COURT: Yes, ma'am.

BY MS. AGNEW:

Q. Dr. Carinci, I want to now talk about the actual MWAP request form data that you examined and your conclusions based on that data.

A. Okay.

Q. I want to direct your attention to your third subject heading on page 40 where you talk about the MWAP request forms themselves and your conclusions based on the data you saw

within the forms and/or the summaries that you examined.

A. Sure. So of those 10,000 request forms, as I talk about in my report here, 6385 were approved. This is just sort of the raw information.

2,866 of those approved were for medication administration of 14 days or less; 3,519 approvals were for prescriptions of 15 days or more. When you sort of track that through the patients what became clear in fact was that these were not approvals for medications that were continued for months on end.

In fact, what it became clear was of those 14 days or less, many of those MWAP approvals were for patients who had an acute issue such as surgery or an injury, some sort of trauma, and they were medications that were meant to only last approximately two weeks. And so they were for acute pain issues.

On top of that, those other approvals that were beyond 15 days, many of those were also for post-surgical pain for instance; but more importantly many of those approvals were for actually tapering the medications over multiple months. And so whereas on the face of it, it may look like, okay, 3,519 MWAP approvals for more than 15 days, if you actually started tracking that through the patients that were provided these approvals, it really was for tapering the medications down month after month.

And so ultimately that face value of that data does not indicate that all of those folks were maintained on an MWAP. In fact, it means that the vast majority of them were tapered over time when you actually tracked it through the patients. So that was the value of that analysis of looking at that data in a very 10,000-foot view, and then drilling down the specifics of each of those patients to sort of track what actually occurred with those MWAP request forms.

Q. And what about your conclusions regarding one of your culprits as you put it, Neurontin and that's interchangeably gabapentin just for the record?

A. It was a similar type of process. So as I outlined on page 41 there, 268 were female. Of the 1440 total Neurontin patient requests, 833 were only made once, with 50 of those for female; 545 of those one time request were denied. The other 288 approved, but not again requested.

So I think it's the similar theme where we're seeing these approvals and they will show up as an MWAP approval, but that is not a testament to the fact that the MWAP process and implementation was in fact providing these medications for an ongoing basis. In fact, what it shows when you actually drill into the data is that these medications were being approved for tapering purposes.

Q. And then you have some conclusions based on your review of that data about a phrase used repeatedly, insufficient medical

justification. Can you explain that to the Court?
A. Right. And so again in that summary sheet that we spent sometime talking about, and then when I spot checked many of these actual MWAP request forms, you would see this particular phrase show up quite frequently. No medical documentation or insufficient medical justification to refuse these medications, when in fact the actual RMDs really didn't have access -- as we talked about, really had no access to the patient, no access to the patient's chart, no access to their history.

And really it was just unclear how that determination was being made. It really wasn't substantiated by anything specific to the individual patient. And so that was concerning as I saw that. Importantly too, and I think I go on to talk about it here. That was the next paragraph, the off label you saw. I'll hold on that statement, but suffice it to stay with the point we're making here is that the RMDs couldn't have made individualized medical decisions without access to the patients' medical chart or history.

So to say insufficient medical justification really is not substantiated in the records available for review.
Q. And what about the off-label use that you just mentioned?
A. So another comment that came up fairly frequently was this statement of not FDA approved or off-label use.

In medical practice, particularly in my specialty, you know, many of these medications are used off label or not FDA

approved, so I think it's an interesting statement. It doesn't really make sense in the context of clinical practice because many of these medications are used in off-label manner and not in an FDA approved fashion.

Just to take a step back so that my point of view is clear, for instance, a medication may be FDA approved for a particular condition only when there's been a specific clinical trial that addresses a specific question. In other words, is gabapentin more effective than placebo for diabetic peripheral neuropathy.

If the results of a clinical trial do indicate that is the case, then gabapentin will be FDA approved for diabetic peripheral neuropathy. On the same token, however, in the practice of pain medicine and the practice of medicine in general, medications are often used off-label through just the practice of medicine. And so, for instance, gabapentin where it is not FDA approved for lumbosacral radiculopathy or cervical spondylosis or any number of other conditions, it's quite frequently used, and in many of the guidelines listed as a first-line medication for those very conditions.

And so to state that the medication is not appropriate because it's off-label or not FDA approved for that condition, again is not consistent with the practice of medicine.

Q. As we expand on that, we mentioned earlier the repeated prescription of a medication like cymbalta. Is cymbalta FDA

approved for the treatment of neuropathic pain?
A. It's hard to know now because there's always updated studies. My understanding is that it is not for neuropathic pain, it may be for like musculoskeletal pain. But nevertheless, the particular FDA indication for the medication is not a reason to prescribe or not prescribe for a particular condition.

In other words, these medications, just to be clear, in the practice of medicine are utilized off-label for many, many indications, and not just in the realm of pain medicine. In the practice of medicine in general, medications are used off-label for treatment of various conditions.

Q. And now let's talk about your conclusion based on the data pulled from the MWAP request forms. You say RMDs were not following the standard of care. Can you expand on that?
A. Yes. As we talked about early on, one of the big issues -- let's back up for a moment and say what was the standard of care with regards to the MWAP implementation. And that was individualized patient assessment.

And it's very clear that the decision maker in this process was the RMD. And for the RMDs to make these decisions, they had no ability to ascertain the individual patient parameters to be consistent with the standard of care. In other words to be more specific, they did not have access to the patient. They were not examining the patient. They did

not have access to the patient's medical record, and they had minimal, if at all, patient specific data to make these decisions. And so really all they had was the MWAP request form that did not contain this relevant information.

And so for that reason, they're not following the standard of care as we outlined earlier.

(Continued on next page)

BY MS. AGNEW:

Q. I just have a few more questions, and the first is, you know, we talked a lot about the abuse potential of opioids during the course of your testimony. Did you find that there were patients within your 70-patient sample for whom opioid treatment would be appropriate?

A. Yes, there were some patients.

Q. OK. Do you recall -- and you're welcome to refresh your recollection -- the condition of those two patients and why in that particular, those two particular instances it was appropriate?

A. Yes. I'll be honest. The names escape me now, and I would have to take time to review them, but I remember their history was significant for sickle cell anemia. Sickle cell, you know, just to sort of set the stage with regard to the problem, is a condition that can be provoked due to pain. And so in these particular instances -- I think in both cases -- the patients were maintained on opioid therapy that managed to lessen the frequency of these flares as well as control their baseline pain. Unfortunately, as the medical records would indicate, they were tapered off their opioid therapy, you know, really despite multiple requests from the hematologists or the specialists taking care of them to maintain them on opioid therapy in order to prevent the exacerbation and the sickle cell flares. And so in these two instances, you saw repeated,

you know, hospitalizations, repeated readmissions to the hospitals for sickle cell crises due to poor pain control as a result of their opioid therapy being tapered down.

And again, as a pain management provider, I understand the implications of, you know, flagrant opioid prescribing, but there are obviously patients that benefit from opioids in a controlled fashion particularly when we document efficacy. And to have a scenario where a specialist is repeatedly recommending, you know, reinstituting an opioid regimen that was found to be efficacious and, on top of that, seeing repeated, you know, hospitalizations for sickle cell crises as a result of insufficient pain, I think, was really a testament to the misuse of the MWAP policy.

THE COURT: Insufficient pain or insufficient pain treatment?

The record says, in the middle of your answer, "seeing repeated hospitalizations for sickle cell crises as a result of insufficient pain, I think, was really a testament to the misuse of the MWAP policy."

Did you mean insufficient pain?

THE WITNESS: Insufficient pain management or poorly controlled pain, to be clear.

THE COURT: Thank you.

BY MS. AGNEW:

Q. Dr. Carinci, finally, as we all know, one of the

justifications for the MWAP policy is the abuse potential and abuse history of these patients. When you reviewed their medical records, did you take that into consideration?

A. Yes, I did.

Q. OK. And where would you have seen that?

A. Well, that would have been in various areas. Certainly within the context of the medical records. There were also sort of urine drug screens or urine drug tickets or -- yeah, I think they called them behavior tickets where these sorts of things would be documented. But yes, those were apparent in the records as well as the patients' history. It may indicate prior history of drug abuse or substance abuse. And so, yes, that was clearly something that was on my radar.

Q. OK. And I just want to make the record very clear. Did you actually see the disciplinary tickets themselves or references?

A. I don't recall seeing the tickets. I think these were just references.

Q. OK. And Dr. Carinci, did my office -- was my office able to provide you with the criminal histories of these patients?

A. Not that I recall.

Q. OK. Tell me something, Dr. Carinci. In conclusion, based on your direct testimony, did you make any mistakes in your report?

A. Yes.

Q. OK. Can you give me an example of a mistake you might have made?

A. Well, I think, you know, just taking a step back for a moment, this is probably the biggest report I've personally ever written. You know, again, I did this myself. I did not have any assistants helping me with this. I also understood that there was an essence -- you know, time was of an essence, given that there were people suffering here. And so there may be some oversights in some of my summaries that I put together.

One particular one, I think, was fleshed out during my deposition, where I had indicated that the provider had never mentioned that the patient had myelopathy, which was true in one of the reassessment forms but was clearly documented in the second reassessment form. And so, you know, clearly I over -- it was an oversight by saying that it was never mentioned when it was only mentioned in one of the two. That was one particular issue that showed up in my deposition.

You know, there may have been other, you know, sort of small either grammatical or, you know, documented a wrong dose, or something like that. There could be many of them in a report this size and given the voluminous records that I reviewed.

I think the point is, however, that none of those errors were systematic errors that would affect the overall conclusion in this case. You know, whether that particular patient had

myelopathy or not is not going to alter the overall opinion in this matter. You know, clearly we all strive for 100 percent accuracy, but you know, again, when you're putting a report like, of this size together, there's going to be some errors. Again, I stand by the report. There's no systematic errors that would affect the overall conclusion, however.

MS. AGNEW: Dr. Carinci, I've concluded my direct, and I'm going to turn it over to my colleagues.

THE COURT: Thank you.

Cross-examination, counsel.

MR. NOLAN: Thanks, your Honor.

THE COURT: Yes, sir.

CROSS-EXAMINATION

BY MR. NOLAN:

Q. Good morning, Dr. Carinci.

A. Good morning.

Q. My name is Will Nolan. I'm one of the attorneys for Dr. Moores, the chief medical officer at DOCCS. I've got some questions for you today. OK?

A. All right.

Q. OK. First, we are going to go through some of your qualifications and just make sure I understand -- and I think counsel already alluded to this, that we'd be asking -- you never worked in a prison before?

A. No.

Q. OK. You never worked in any correctional facility or setting?

A. No.

Q. OK. Your experience with the correctional setting then is based on your services in this case and one other. Do I have that right?

A. When -- could you clarify what you mean by my services particularly?

Q. The work that you've done with prisoners in an incarcerated setting.

A. Well, I think, I mean I would separate out, like, the sort of serving as an expert witness from serving as a physician. As I've indicated, I have taken care of, you know, incarcerated patients. But as an expert witness, yes, this would have been the second case.

Q. OK. And the first case, was that *Medina v. Buther*?

A. Yes.

Q. OK. And that was in this court?

A. Yes.

Q. And other than this case and the *Medina* **case, do you have any experience actually speaking or treating with prisoners who are actually -- while they're in the correctional setting as opposed to outside in your own office?**

A. Well, again, I guess I'm just trying to clarify, you know when a prisoner is sent to my office for medical care, I would

consider that treating the patient.

Q. And when they're sent to your office for medical care, are they being sent to your office in your capacity as a pain management specialist?

A. Yes.

Q. OK. And when you're treating patients as a pain management specialist, do you typically follow patients for a long period of time, or do you see them only a few times as a consultant?

A. Generally, it's longitudinally over time, for long periods of time, the majority.

Q. OK. You mentioned the *Medina* **case before. I just wanted to clarify. The attorney representing the plaintiff in that case was Ms. Agnew, is that correct?**

A. Yes.

Q. **You were paid for your services in the** *Medina* **case***?*

A. Yes.

Q. OK. How much were you paid?

A. I don't recall.

Q. OK. Do you know what the terms of your compensation were?

A. Yes.

Q. And what were they?

A. You mean, like, an hourly rate?

Q. Sure.

A. $800 an hour.

Q. OK. Do you have an idea of how many hours you spent on

that case?
A. I don't. I'm sorry.
THE COURT: I'm going to ask you to slide in a little closer to the microphone again, please, sir.
THE WITNESS: Oh, sure.
BY MR. NOLAN:
Q. How about this case; are you being compensated for your time?
A. Yes.
Q. OK. And do you know how much you've been paid to date on this case?
A. In the order of about 50,000, I think, over approximately three years.
Q. And what are the terms of your compensation; by hourly rate?
A. Some is hourly. You know, record review, phone conversations, Zoom meetings, those sorts of things are hourly. There's other things, like deposition -- well, deposition testimony was hourly as well. But court appearance or when I went out to examine some of these claimants, those are more flat-rate fees.
Q. When you're charging an hourly rate for this case, what was the rate?
A. 800.
Q. OK. And the flat fees?

A. Well, for today, testifying is 12,000.
Q. And to be clear, with respect to your areas of expertise, are you an expert in treating addiction?
A. No.
Q. OK. Have you served on any corporate boards, scientific advisory boards of any type?
A. Yes.
Q. And can you identify those for us?
A. They would have been listed in my CV. It's not something I've done in probably the last five or six years, but in the past I was asked, primarily when I was at, you know, Harvard and MGH, to participate in a medical advisory board, which was essentially just a meeting of physicians from around the country to review data with regards to new medications and to offer your opinions about what you felt were -- did this medication have an applicability for patients?
Q. OK. And was one of the boards that you sat on Mallinckrodt Pharmaceuticals?
A. Yes.
Q. You sat on that board from 2013 to 2014?
A. No. This was just a one-time meeting.
Q. OK.
THE COURT: I think the question was: "And was one of the boards that you sat on Mallinckrodt Pharmaceuticals," right?

MR. NOLAN: Yes.

THE WITNESS: And my answer was yes.

BY MR. NOLAN:

Q. And did you sit on that board in 2013 and 2014?

A. No. I think the way you're interpreting that from the CV is that was the academic year. But it's -- it was just a one-time meeting. This is not like I was on a board that met consistently. These scientific advisory boards are essentially one-time meetings, where there might be a specific date where we all met at a conference table; might have been a hundred doctors that were there.

Q. Did you get paid for that?

A. Yes.

Q. Do you recall how much you got paid for your work with Mallinckrodt?

A. No, I don't.

Q. Mallinckrodt is a pharma company, correct?

A. Yes.

Q. And it's one of the biggest manufacturers of opioids in the U.S., right?

A. I don't know about that.

Q. Does it sell or market opioids?

A. I don't know.

Q. You don't know?

A. I don't know.

Q. OK. Do you know whether it sells fentanyl?
A. I don't know.
Q. How about Collegium Pharmaceuticals; did you sit on that board?
A. Yes.
Q. And that's also a pharma company, correct?
A. I don't know if they're still in existence, to be frank, but they were at least at one point.
Q. Did they sell and market opioids?
A. I don't know.
Q. Were you paid for your work for Collegium?
A. Yes.
Q. Do you know if they sold Xtampza?
A. Yes, they did.
Q. How about Cubist Pharmaceuticals; did you serve on the scientific advisory board for Cubist Pharmaceuticals?
A. Yes.
Q. OK. And was that in 2012 and 2013?
A. Again, it's a one-time meeting. It was probably in that academic year, 2012 to 2013.
Q. And were you paid for that work?
A. I don't recall.
Q. And do you know what they made, what pharmaceuticals?
A. I think it's a nonopioid agent, although I -- you know, it's quite a while ago. I don't recall specifically.

Q. How about Covidien Pharmaceuticals; did you serve on a scientific advisory board for Covidien?
A. I think that was the same with Mallinckrodt. I can't recall specifically. This is probably going back a decade or so at this point.
Q. OK. Were you paid for that work?
A. I don't recall.
Q. Did you serve on any board for Abbott Labs?
A. No.
Q. Did you do any work for Abbott Labs at any time?
A. I taught spinal cord stimulater implant classes. I think I did one of those in, I want to say 2020, '21, possibly.
Q. Were you paid for that work?
A. Yes.
Q. And does Abbott Labs, to your knowledge, partner with pharma companies to sell drugs?
A. No.
Q. You've served as an expert in litigation plenty of times, right?
A. What do you mean by plenty?
Q. Well, how many cases have you testified in?
A. 12 case -- you mean in the court testified?
Q. Let me start with in court.
A. I think this is my 14th or 15th court appearance.
Q. OK. And how many times have you been retained to be an

expert?
A. Since 2009, over a hundred times.
Q. OK. And you provided an expert opinion in a case called State of Ohio v. Frank Lazzarini, correct?
A. Yes.
Q. And Mr. Lazzarini was a doctor in Ohio, is that correct?
A. Yes.
Q. And you testified on his behalf or as his expert?
A. Yes.
Q. And he was accused of running a pill mill, is that correct?
A. Yes, he was.
Q. What's a pill mill, for the record?
A. A pill mill would be a practice that provides opioids fairly indiscriminately, I think, if you're talking particularly about opioids, indiscriminate without really caring to treat the patient, just to provide the opioids.
Q. For that case you reviewed the medical records of Mr. Lazzarini's pain prescriptions, right?
A. Could you ask the question again?
Q. You reviewed the medical records related to Mr. Lazzarini's pain prescriptions?
A. Yes, I did.
Q. And you actually opined that all of the pain prescriptions he wrote were medically sound, right?
A. That's not true.

Q. Mr. Lazzarini -- he was convicted in engaging in a pattern of corrupt activity, telecommunications fraud, Medicaid fraud, tampering with a record, grand theft, involuntary manslaughter, aggravated drug trafficking, drug trafficking and illegal processing of drug documents. Is that your understanding?

MS. AGNEW: Objection. I'm objecting to the relevancy of the criminal conviction of a client of Dr. Carinci's.

THE COURT: Mr. Nolan.

MR. NOLAN: Well, I think it's relevant in that it goes to bias and it goes to credibility.

MS. AGNEW: I don't know why Dr. Carinci's client's conviction for criminal charges goes to bias or credibility. There might be other ways to elicit testimony that meets that mark, but I don't think this is it.

MR. NOLAN: Why don't I take a step back. I withdraw the question for now, but I have more questions about that case.

THE COURT: All right.

Off the record.

(Discussion off the record)

THE COURT: Mr. Nolan.

BY MR. NOLAN:

Q. In the Lazzarini case, Dr. Carinci, you opined that Dr. Lazzarini exercised good medical judgment, correct?

A. In some of the cases -- in some of his patients, yes.

Q. And in fact, one of those patients was prescribed Percocet, fentanyl, alprazolam and hydrocodone all in one day, is that correct?
A. I don't know. Which particular patient? I mean you're asking me something that's very generalized.
Q. Do you know whether Mr. Lazzarini is still a doctor?
A. I don't know.
Q. You also provided an expert opinion in Rhodes v. Fred W. Albrecht Grocery Co., correct?
A. That does not sound familiar to me.
Q. That was an Ohio case?
A. Doesn't sound familiar.
Q. Do you recall Dr. Higley in that case?
A. I don't.
Q. You don't recall being retained by Dr. Higley?
A. No.
Q. Why was this on your CV?
A. That would not have been on my CV.
Q. OK. I want to talk about some of the assumptions in the report that we talked about earlier, which is in the record as P137. Do you have that before you?
A. I do.
Q. OK. Now, the assumptions that you made, and just looking at the first assumption on the second page, that relates to the MWAP policy, right?

A. Yes.
Q. And the second assumption also relates to the MWAP policy, right?
A. Yes.
Q. And the third assumption relates to the MWAP policy?
A. Well, I think -- yes, it does. I mean all of this relates to the MWAP policy.
Q. All of them relate to the MWAP policy. OK.
And are you aware that the MWAP policy was rescinded on February 8, 2021?
A. Yes.
Q. Are you aware that it was replaced with a new policy?
A. I'm not.
Q. OK. So you don't know what any new policy would be called?
A. Correct. I do not know.
Q. And you were not retained to provide any opinion about any medical care given to any inmates or prisoners or patients of any type in this case under any new policy; is that fair?
MR. NOLAN: Objection, your Honor.
THE COURT: Basis.
MS. AGNEW: So, the medical records that Dr. Carinci examined in some instances do go longer and go past the point of the new policy. Dr. Carinci wouldn't know whether or not that was in effect. But I want the record to be extremely clear of that fact.

THE COURT: You don't object to that, do you, counsel?

MR. NOLAN: Well, I object to Ms. Agnew testifying for him, yes.

THE COURT: Do you dispute the facts with respect to the time period over which the medical records Dr. Carinci looked at extend?

MR. NOLAN: I dispute that as evidence in any way to support what she's saying so far based on Dr. Carinci's testimony.

MS. AGNEW: Your Honor, I'll withdraw my objection. Let's move on.

THE COURT: Yes, ma'am.

BY MR. NOLAN:

Q. But just to be clear, have you heard of a policy called 1.24A?

A. No.

Q. And just to be clear, you aren't here rendering an opinion about anything to do with 1.24A, correct?

A. Correct.

Q. All of your opinions relate to the MWAP policy, which has now been rescinded, correct?

A. Yes.

Q. Your report is dated May 5, 2022, correct?

A. March 5, 2022.

Q. Sorry. Yes. March 5, 2022.

And so it's fair to say that you concluded your review of records before March 5, 2022, correct?

A. Well, I think, you know, the date of my report is the date of my conclusions.

Q. OK. And do you know what the last date of the last dated record you looked at in terms of all the medical records?

A. Not offhand, no.

Q. Was it dated 2021 sometime?

A. I don't recall without looking at the specifics.

Q. But you certainly didn't review any medical records that dated after March 5, 2022; fair to say?

A. Correct.

Q. OK. And so you didn't render or come up with any opinion that any group or class of patients -- well, actually, let me take a step back.

One of the aims of your report was to determine whether the MWAP policy injured patients through a deviation from the standard of care. Is that fair?

A. Yes.

Q. And you were looking back at what the individuals -- when you use the term "injured," which is right there on the first page, that's past tense, right?

A. To an extent, past. But you know, keep in mind that I did examine, you know, 17 of these individuals. So that would have been current as well.

Q. And when you say current, that was in 2020 or 2021 that you examined them?

A. Yes, the date of the examinations.

Q. OK. Not in 2022?

A. No.

Q. Not in 2023?

A. No.

Q. OK. And so your report also doesn't contain any opinion that any group or class of patients were going to suffer any future harm, does it?

A. Future as in from, like -- can you be more specific? What do you mean?

Q. Well, you have the report in front of you. At any point in time, did you opine in your report, is there anything there that you see that suggests that anybody was in danger of imminent harm of any type?

A. Well, I think, yes. I mean I would disagree with what you're saying. Yes, there were. We talked about those two sickle cell patients were repeatedly admitted. I would say that those in particular were harmed.

Q. And what happened to those after the date of your report; do you know?

A. I don't know.

Q. And you can't render an opinion as to whether they suffered any harm after the date of your report; fair?

A. Correct. I mean I do know that many of these individuals, as I outlined in my report, once they were released into the community, were restarted on many of their efficacious medications.

Q. So some of these individuals are no longer with DOCCS, correct?

A. Correct.

Q. In fact, many of them are no longer with DOCCS?

A. I don't know.

Q. Do you know if any of them are still with DOCCS?

A. I don't know.

Q. When you refer to an injury through a deviation from the standard of care, you're referring to the standard of care for the treatment of pain conditions, is that correct?

A. Yes.

Q. OK. And can we agree that when we refer to standard of care, we're talking about a benchmark or to measure whether a medical provider is meeting his or her obligations to a patient?

A. I'm not sure I would define it that way, but I think I'm following you in general, yes.

Q. All right. But isn't it also true that when it comes to the treatment of pain conditions, there is no recognized standard of care?

A. No, that's not true.

Q. We talked about your work in the *Medina* **case earlier, correct***?*

A. I don't think we really talked much about my work. You --

Q. We recognized that you were an expert in that case, correct?

A. Yes, sir.

Q. OK. You gave testimony in that case, correct?

A. Yes.

Q. And you appeared in this court and gave testimony, correct?

A. Yes.

Q. And that was on September 18, 2018 --

A. I don't recall.

Q. -- is that fair?

But you do recall testifying?

A. I do.

Q. And you swore to tell the truth?

A. Yes.

MR. NOLAN: I'm going to read from page 275, lines 4 through 8 of the transcript of that testimony, which, for the record, is located at Dkt. No. 392 from the *Medina* **case.**

Q. You testified --

THE COURT: Can I just ask you what we're doing; are we putting it in front of the witness? Or what are we doing here, sir.

MR. NOLAN: I'm impeaching the witness with his prior

inconsistent statement.

THE COURT: OK. Are we going to put it in front of him?

MS. AGNEW: Your Honor, I actually don't have a copy.

MR. NOLAN: There's nothing that requires me to put it in front of him, your Honor. If you want me to put it in front of him, I can, but I'm not required to.

THE COURT: All right. Well, I think you ought let counsel look at it over your shoulder.

MR. NOLAN: Yeah, I think counsel's familiar with her client's testimony.

MS. AGNEW: He's not my client, and I don't have it memorized.

Can I take it?

MR. NOLAN: No. You can read it.

Q. You testified, did you not, that there's really no standards of care for treatment?

THE COURT: Counsel, question, answer.

MR. NOLAN: Well, the question was: "Sir, are you able to answer the question?"

You posed that to him, and he testified --

THE COURT: Counsel.

MS. AGNEW: I believe that --

THE COURT: Counsel.

MR. NOLAN: Your Honor, under the rules --

THE COURT: Two things. No. 1, talk into the microphone or we can't have it taken down.

Two, you have to ask the question and give the answer that you want to read.

MR. NOLAN: I will ask the question and give the answer, and I'll let Ms. Agnew look over my shoulder.

MS. AGNEW: Wait.

MR. NOLAN: OK.

"Q. Is there any standard of care for keratoconus-related pain?"

Answer --

MS. AGNEW: You have to read it all.

MR. NOLAN: Keratoconus-related pain.

"Ms. Agnew: Objection. The witness is not an ophthalmologist, nor has he been qualified as one.

"Mr. Schulze: He is a pain specialist.

"The Court: Sir, are you able to answer that question?

"The Witness: Well, there's really no standards of care for treatment of really any pain conditions. That's really a decision between the patient and the physician. There are certainly guidelines, but I would hesitate to call any of these standards of care."

Q. That was your testimony, correct?

A. Yes.

Q. Yet your report contains several pages in this case on standards of care related to pain conditions. Is that fair?
A. Well, I think you're misallocating my opinion with regards to conditions versus pain management. You know, you first asked me are there standards of care in pain management. I think that's a different question of is there standards of pain management relative to particular pain conditions. I mean, you know of course there are standards of care in pain management. There may or may not be standards of care in particular pain conditions. But I think both of my answers are consistent.
Q. OK.
A. I don't think that there's any evidence that they're not consistent.
Q. OK. I'll now read from page'77 of your transcript in that case.
"Q. Well, is it fair to say then there's not one standard of care that should be followed in regard to keratoconus-related pain, correct?
"A. Right, and as I said before, I would hesitate to use the term 'standard of care' with regards to pain treatment. There really are no specific standards of care relative to the treatment of pain. It's more of a guideline-based, physician's-based discussion."
Again, that was your testimony in the *Medina* case, correct?
A. Correct. And again, it is consistent with my current

position as well.
Q. It's consistent with your current position that there is a standard of care; is that what you're saying?
A. What you're asking me about is a specific standard for a specific condition.
Q. You said any pain condition.
A. Right.
Q. Thank you.
A. Any condition. But what I'm talking about is there are standards of care in pain management. There are certainly standards of care in pain management. There may or may not be standards of care for particular pain conditions.
Q. Right, but in either case, the ultimate decision, right, is the medical provider? Correct?
A. The ultimate decision for what.
Q. Whether to prescribe a particular pain medication. Correct?
A. That's not -- are we talking about the standard of care, or are you talking about general --
Q. That's my next question.
THE COURT: Would you be kind enough to let the witness finish --
MR. NOLAN: Sure.
THE COURT: -- so that the reporter can get it down before you start again.

MR. NOLAN: Sure.

Q. The ultimate decision as to whether or not to prescribe a particular pain medication lies with the medical provider, correct?

A. Yes.

Q. All right. And in this case, as I understand your testimony, you're not suggesting that the frontline medical providers as opposed to the RMDs have failed to meet any standard of care, are you?

A. No.

Q. And you, as I understand it, found fault with the RMDs themselves, not with -- just to say it another way, you found fault with the RMDs?

A. Yes, in general.

Q. OK. And you found fault with them because they were the ones that ultimately could provide or not provide the medications, correct?

A. Yes.

Q. OK. Is that still the case?

A. Yes.

Q. Do you know whether the RMDs are still deciding whether or not to prescribe medications?

A. I don't know.

Q. OK. And in this case, when you did your work, the RMDs weren't the ones seeing the patients, right?

A. Correct.
Q. And so the paramount issue for you really was that the RMDs were still the ones making the decisions with regard to treatment with MWAP medications, right?
A. Yes, that was part of it.
Q. They didn't always have the medical records before them; is that fair?
A. Yeah, I don't think they ever the medical records.
Q. But you were not making that conclusion with respect to the frontline medical providers, right?
A. Correct.
Q. You don't know whether they had the medical records in front of them at the time they were making decisions as to whether or not to prescribe any medication?
A. I don't know.
Q. OK. And so when you're talking about the violation of the standard of care in this case, it was the RMD process which ultimately led to that opinion that you have?
A. Well, the standard of care, yes, comes back to the implementation of the MWAP, which is really in the hands of the RMDs.
Q. OK. We established that your report's dated March 5, 2022. And just to be clear, you didn't review any medical records of any patients on that -- that postdate that report, right?
A. I don't think so, no.

Q. OK. And you weren't asked to opine on any patient's treatment after February 8, 2021, were you?
A. I don't think so.
Q. OK. And so you can't testify today as to the care and treatment of any patients in DOCCS custody postdating your report?
A. Correct.
Q. And you can't testify that, as of today, any particular patient is getting the care they need or not?
A. I don't know.
Q. OK. And you reviewed medical information for, you said, 70 DOCCS patients?
A. Yes.
Q. And -- but you saw only 18 of them; is that fair?
A. Could you ask the question again? I got distracted.
Q. You actually examined 18 of them?
A. Yes.
Q. OK. What about the others; you didn't examine them?
A. No.
Q. OK. How did you select the 18?
A. I didn't select them.
Q. Who selected them?
A. I think Attorney Agnew in concert with the defense team.
Q. How about the other -- I'm bad at math -- other 52; you just reviewed their medical records?

A. Yes. I did not examine those others.
Q. OK. And how were those others selected?
A. Those were -- those were -- I don't know exactly how they were selected.
Q. Well, how did you determine that you were going to look at those particular records?
A. That was the list of patients that was provided as a sample of the population.
Q. OK. As I understand it, you found the number of documents to be unmanageable. Is that fair?
A. Well, I don't know if it was -- I wouldn't say it was unmanageable. I think I managed to get through the documentation. I think unmanageable would have basically not resulted in a report. I think -- I would say these were voluminous records.
Q. OK. And if you'd just look at page 9 of your report, under patient file review, section II, there's a subsection A. Do you see where it says, "Due to the unmanageable number of documents"?
A. No.
Q. Do you see that word?
A. Could you just point me -- how far down are you?
Q. Third line down of the paragraph in the middle.
A. OK.
Q. And you used the word "unmanageable" number of documents,

correct?
A. OK.
Q. So you did find the number of documents to be unmanageable, right?
A. Right. I see the point you're making. I think, you know, the way I'm interpreting your question to me, however, was, like, unmanageable meaning like you couldn't actually get through them in an efficient manner.
Q. OK. And to do it in an efficient matter, you had the legal team create subsets of documents for you?
A. Yes. So, I, as I outlined here, asked that a summary be created. I asked for particular information, nine bullet points, as I mention here, information, that I wanted a 10,000-foot view of each patient with references to the underlying medical records so that I could get a sense for the patient, get a sense for the issues, again, not looking for any emotive statements, not looking for any interpretation, just raw data that I could use to more fully delve into each of the individual patients.
Q. So for the subsets of documents that were created for you, you refer to them as the important documents in your report, correct?
A. Yes.
Q. And so naturally, certain medical records were left out of your review then, correct?

A. No, that's not true.
Q. Well, what were the unimportant documents, or were there none?
A. Well, there's a level of importance in terms of putting together a 10,000-foot view summary that I would consider important, and those are the ones that are outlined there.
Q. OK.
A. There was -- pardon me.
There was the ability to then delve into the additional remainder of the records, which may have been of lesser importance in some instances or perhaps even more important. But in general, to get the 10,000-foot view, these were the important things I wanted to see.
Q. OK. And so let's take a look at these. The list that you have on page 9 of your report, there's eight different categories of documents that it says that you had the legal team curate, I guess. Is that fair?
A. Yeah. I have nine, nine bullet points here.
Q. Sorry. Nine. Fair enough.
And so it says, "The legal team was directed to include any available documents related to" -- let's take the first one -- "drug abuse or allegations of the same."
Who did -- who directed the legal team to do that?
A. I did.
Q. OK. And who from the legal team did you direct to do that?

A. Well, I communicated to Attorney Agnew.
Q. OK. So am I correct in understanding that Attorney Agnew was directed to include, among other things, documents related to drug abuse or alleged drug abuse?
A. Yes.
Q. OK. So you left it up to the legal team to determine what records related to drug abuse or alleged drug abuse, correct?
A. What do you mean I left it up to the legal team?
Q. Well, you directed them to include them, correct?
A. Correct.
Q. Which means you didn't have them, correct?
A. What do you mean by "have them"?
Q. Well, you had to get them from somewhere; fair?
A. No. I had them.
Q. OK. So why were you directing the legal team to prepare these for you if you had them?
A. Well, as I mentioned to you, I'm asking to put together a summary of the basic 10,000-foot view of each patient so I can have an understanding of what the issue was.
Q. OK. But I'm not --
A. I'm just looking for the facts in the case here that then I could use to delve into the specifics, the medical records, to really reach a conclusion about what the issues were.
Q. OK. And maybe there's some confusion, but as I understand it, there were summaries that were created by the legal team

that were narratives. Is that fair?
A. Yes.
Q. And you didn't rely on those, you said; you just used them as a 10,000-foot view, right?
A. Correct.
Q. But then there were the documents that you directed them to include to base their summaries on. Is that fair?
A. The summaries -- so, I think you're perhaps looking at it incorrectly or maybe I'm misunderstanding your interpretation of it. The summaries were to be composed, in part, with these nine pieces of data that I'm asking for. I wanted the summaries to be based upon that.
Q. Right. So the nine pieces of data that you were asking for, like -- for example, the first one was documents related to drug abuse or allegations of same. OK? That's something that you asked the legal team to get to you, correct?
A. No. I had it.
Q. You had it. So -- but why does it say, "The legal team created subsets of important documents pulled from each patient's voluminous records"? OK. So is what you're saying you had all of the records, but you had the legal team go through them for you to pull out what was important?
A. No. I think you're misinterpreting what I'm saying, or --
Q. Please explain.
A. I had the records. All of the records were forwarded to

me. For instance, if I wanted to get a better understanding or an initial understanding of patient A, I would read the summary to get a sense, OK, here's just from, just facts about patient A based on these nine items that I asked for. From there I can then delve into the individual records to delve into more specifics to formulate my opinion. But I had all of the records.

Q. OK. So the subsets that were created, those came from the records that you had?

A. Yes.

Q. OK. Once you had the subsets, did you go back and review all the other records, or did you just rely on the subsets?

A. **No. The subsets were referenced -- the medical records, underlying medical records are referenced to the subsets, so I had access to all of it.**

Q. Right. I'm not asking whether you would access to it. I'm asking, when you reviewed it, were you relying on the subsets for your opinion --

A. No.

Q. You were relying on the subsets created by counsel, correct?

A. No. That's not correct at all. I relied on the underlying medical records to formulate my opinion.

Q. OK. So then you didn't need them to create subsets; fair?

A. No, that's not correct. It was helpful to me to get a

10,000-foot view of each patient.

Q. OK. And to get the 10,000 view of each patient, legal team created a summary and attached medical records to support that, right?

A. There were references to the underlying medical records. I don't -- I wouldn't use the term "attached"; I am not sure what you mean specifically by that. There was a summary, based on the information I requested, that gave me a broad overview of the patient, what was the salient issue that we were dealing with here? From there I could delve into the underlying medical records to formulate my opinion.

Q. OK. So let's talk about just the subsets without regard to your reliance one way or the other.

It was the legal team who was directed to create those subsets, right?

A. I asked them to put together summaries based on those nine data points.

Q. OK. But your report uses the term "subsets."

A. OK.

Q. OK. So you asked them to create subsets, right?

A. I asked them to create summaries from those subsets, yes.

Q. But it says here that you asked them -- they were directed to include certain documents in subsets?

A. I mean, look, I feel like I answered your question ten times, which -- what more would you like me to say?

Q. I guess the question is did the legal team curate any documents for you?
A. What do you mean by curate? I mean --
Q. You used the word in your report, "curate" --
THE COURT: One at a time, friends. Let the witness finish before the question starts.
A. I think to just put it very simply, there's voluminous records. There's 70 patients with many years of data, and for me to get an understanding of patient A, I identified nine pieces of information that I wanted put together into a factual summary from which I could then read, as a 10,000-foot view, to get a general sense for things and then delve into the underlying medical records to formulate my own opinion.
Q. Fair enough, but the last two sentences of the middle paragraph on page 9 says: "The legal team also wrote a synopsis of these curated medical records." What did you mean by curated?
A. It's exactly what I'm telling you. They put together the summaries based on those nine pieces of information, those curated pieces of information that were pulled out.
Q. All right. Let's go through it slower.
"The legal team also wrote a synopsis." is the synopsis a summary?
A. Yes.
Q. OK. And those were based on curated medical records; fair?

A. Yes.
Q. OK. Who created the curated medical records?
A. They did based on my request for those nine pieces of information.
Q. OK. So the legal team determined what fell within those nine pieces of information, right?
A. As a first pass, they did. But again, I was able to then go into the primary records and spot-check those, review them, delve into the substance of them.
Q. How --
A. I didn't rely upon their summaries to formulate my opinion, if that's what you're getting to.
Q. Right, but you relied on the summary to figure out what the issues were, correct?
A. No. I --
Q. You didn't rely on the summaries at all?
A. I did rely on the summaries to get a 10,000-foot view of each patient. But I wouldn't say that all of the issues were embodied in those summaries, because it was just factual data.
Q. OK. Once you saw something in the summary, you then went to the curated medical records to figure out whether it supported what was in the summary?
A. No. The summaries -- I reviewed all of the medical records for each patient. The summaries were in addition to that as a first pass to just review and get a 10,000-foot view of what

was going on.
Q. OK. So why didn't you just have them summarize all the medical records?
A. I don't think that was practical.
Q. OK. But somebody had to determine what was relevant, right?
A. I determined what was relevant.
Q. OK. And so you directed them to include specific things about drug abuse or allegations of same, right?
A. As an example, yes.
Q. Yeah. And the legal time determined what related to drug abuse or allegations of same and gave it to you, right?
A. No. I had it all. I think you're misunderstanding.
Q. So there was no purpose to what they were doing?
A. No, that's not true.
Q. What was the purpose?
A. To provide a 10,000-foot overview of the patient's history. Whether they had all of the drug tickets in there or one of them, I went back to the main medical records to review them. The summaries just got me going so I had an initial sense of each of the patients. That's really it.
Q. So, for example, if you went to a patient's summary, you didn't see anything related to drug addiction, right, did you then look at the curated medical records to see if there was anything related to drug addiction?

A. I went through all of the records for each patient. The summaries were just the first pass.

Q. Let's go back. Just answer my question. I'm asking you if when you reviewed the summaries created by the legal team and let's say, for example, you say nothing related to drug abuse or allegations of same -- OK? Are you with me?

A. Yes.

Q. OK. If you didn't see anything, did you then look at the curated medical records that the legal team put together for you to determine whether or not those records -- whether they missed anything?

A. Yes. I went back to the main medical records.

Q. I'm asking about the curated medical records.

A. I think --

MS. AGNEW: I'm going to now object. I think we're getting to a little bit of badgering at this point.

MR. NOLAN: I'm just really trying to understand the process here.

MS. AGNEW: I think he's explained it many times.

THE COURT: If you want to keep using your time to do this, go right ahead.

MR. NOLAN: Thank you.

THE COURT: But we are getting close to badgering.

MR. NOLAN: I'm not trying to badger the witness.

Q. What I'm trying to understand is if you saw nothing related

to drug abuse in either the summary or the "curated" records -- that's your term -- did you then go and look at all of the records to see if there was anything in there related to drug abuse or allegations of same just to make sure you weren't missing anything?

A. And the answer is yes.

Q. OK. So you reviewed every page of every medical record?

A. Yes.

Q. OK. How do you know that those were complete?

A. I don't know. That was what was provided to me.

Q. It was provided to you by counsel?

A. All of the medical records for each patient that they were in, I had, that they had I had.

Q. OK. So everything you got you got from counsel, and you relied on them to make sure that it was relevant to what you were doing?

A. Yes.

Q. OK. You have 75 exhibits to your report; fair?

A. Yes.

Q. OK. And 70 of those exhibits corresponded to the medical records you reviewed for those 70 patients, right?

A. OK.

Q. Is that fair -- is that correct?

A. I mean I'd have to go back and, you know, do the math on it. But I'll take what you're saying. OK.

Q. OK. And those exhibits, did that comprise all of the medical records that you reviewed in connection with your report?

A. I don't know.

MS. AGNEW: Your Honor, may I? Forgive me. I see you looking at your version of the report. It does not include the medical records.

THE COURT: Good thing.

MS. AGNEW: Exactly.

BY MR. NOLAN:

Q. All right. I'm now going to change topics.

As for patient examinations that you did, you said you did how many -- 17?

A. Yes.

Q. OK. And again, you -- you didn't select those; those were selected for you?

A. That's correct.

Q. OK. I want to focus on the three plaintiffs in this case. Do you know who they are?

A. No.

Q. The named plaintiffs? Do you know who Mark Daniels is?

A. I know the name, yes.

Q. Rashid Rahman?

A. Yes.

Q. And Felipe Rivera-Cruz?

A. Yes.
Q. OK. And you issued a medical opinion or an opinion about the care given to each of those four individuals, right?
A. I believe so, yes.
Q. You didn't physically examine Mark Daniels, did you?
A. I don't recall, but let me just take a quick look.
No.
Q. And you didn't speak to Mr. Daniels before issuing an opinion about his care, did you?
A. I did not.
Q. And you didn't speak to his medical providers before issuing an opinion about his care, did you?
A. No.
Q. And you didn't physically examine Rashid Rahman, did you?
A. No.
Q. OK. And you didn't actually speak with Mr. Rahman before issuing an opinion about his care, did you?
A. No.
Q. And you didn't speak with any of his medical providers, did you?
A. No.
Q. OK. And you didn't physically examine Felipe Rivera-Cruz, did you?
A. No.
Q. And you didn't actually speak with him before issuing an

opinion about his care, did you?
A. No.
Q. And you didn't speak with any of his medical providers?
A. No.
Q. With respect to the 17 patients that you did examine, how many of their medical providers did you speak to?
A. I don't think I spoke to any of them.
Q. Did you speak to any of the RMDs?
A. Not that I can recall specifically.
Q. Did you review any testimony given by any RMDs or medical providers in support of your opinion in this case?
A. Well, let me just go back just for a quick minute just to be clear. When I arrived at the facilities, I did speak with some physicians. I can't recall who they were. They did, you know, bring me to the rooms. They did get me settled, so I don't know specifically who I spoke to. My understanding is that they were physicians that I spoke to.
Q. All right. But fair to say you didn't speak with anybody about the reasons behind any decisions made with respect to the pain management decisions that any medical providers made?
A. No.
Q. And so you can't say one way or the other what their reasoning was, as reflected -- you're just looking at the records; nothing further?
A. I didn't have a conversation with the particular providers,

no.

Q. So you were really just looking at the records?

A. Well, are we talking about the patients I examined in those instances --

Q. Yeah. You were -- yeah, so let me just ask you.

A. -- the providers?

THE COURT: Counsel. Counsel, you've got to let the witness finish.

THE WITNESS: Agreed.

THE COURT: "Well, are we talking about the patients I examined in those instances?"

THE WITNESS: What was your question, sir?

MR. NOLAN: Yeah, I will withdraw the question.

Q. With respect to the patients you did examine, you relied on their records and an examination of them, correct?

A. Yes.

Q. OK. And you -- did you look at anything other than the records, and did -- strike that.

Did you base your decisions or your opinions on anything other than your examination of those individuals and your examination of their records?

A. Well, I would consider the MWAP forms as sort of separate from the medical records. So yes, I looked at those as well.

Q. Anything else?

A. Not that I can recall.

Q. And you testified earlier that the medical records were -- I think you used the word "disarray."

A. I don't know if I used that word.

Q. OK. Were they in disarray?

A. In some instances; in many instances, yes.

Q. And were they difficult to understand?

A. Yes.

Q. And were they illegible in many cases?

A. Yes.

Q. OK. How about the MWAP forms?

A. Some were illegible, yes.

Q. Were any of them handwritten?

A. I don't recall.

Q. Were they difficult to understand?

A. Some of them, yes.

MS. AGNEW: Your Honor, could we get a check on time? I do need a break. I'm happy to wait if it's going to be 15 minutes.

THE COURT: Off the record.

(Discussion off the record)

THE COURT: All right.

Do you want to take a break now?

MR. NOLAN: Sure.

THE COURT: All right.

MS. AGNEW: Thank you.

MR. NOLAN: Your Honor, can I get an instruction that they're not to talk about the testimony?

THE COURT: Of course.

(Recess)

THE COURT: Mr. Nolan.

BY MR. NOLAN:

Q. OK. I apologize for going back to this topic, but you testified that you reviewed all of the medical records for every patient that's referenced in your report. Correct?

A. Yes.

Q. And how many hours would you estimate that took?

A. 60 hours probably at this point.

Q. 60 hours, a lot of work?

A. Right. Was that a question?

Q. Was that a lot of work, 60 hours, for you?

A. Yes, it's a lot.

Q. You recall, again, you were deposed in this case --

A. Yes.

Q. -- correct?

And your attorney was there when you were deposed -- or not your attorney, but Ms. Agnew was there when you were deposed?

A. Yes.

Q. And again, you gave an oath at that time, correct?

A. Yes.

Q. And you swore to tell the truth, right?

A. Yes.
Q. I'm going to read from page 98 of your deposition transcript, lines 16 to page 99, line 6:
MS. AGNEW: Your Honor, he was deposed twice. Can I just ask --
MR. NOLAN: The first one. You can look at mine, if you want.
"Q. So 15 to 20 hours reviewing medical records?
"A. Yes.
"Q. Is that reviewing medical records for each of the 70 patients that you were provided?
"A. Yes.
"Q. Is that 15 to 20 hours per patient or a total for all the material records?
"A. No. That's cumulative, but that doesn't include the time, you know, spent at the facilities examining those individual patients, which was essentially a full day at each of those facilities."
Q. Does that refresh your recollection whether -- as to how long you spent reviewing medical records for this case?
A. Yes. And I know I went on to further clarify that, and I believe we talked about 40 hours further down in the deposition.
Q. And that was for other work that you did other than reviewing medical records?

A. No. I think that was all-encompassing. In addition, you know, we didn't account for the time spent at the facilities.
Q. OK. Fair.
I want to talk a little bit about gabapentin. That's also known as Neurontin, correct?
A. Yes.
Q. Neurontin's just a brand name?
A. Yes.
Q. OK. And we talked a little bit about FDA approval earlier. Do you recall that?
A. Yes.
Q. And what, if anything, is gabapentin FDA-approved for?
A. Well, there's probably multiple seizure diagnoses that it's approved for. I don't know about those. I don't provide it for, you know, seizures, an antiepileptic medication, so there's probably some FDA approvals for seizure-type indications that I'm not familiar with.
Q. OK. And in terms of your practice, in terms of pain management, what is it FDA-approved for, if anything?
A. It may be diabetic peripheral neuropathy, but again, I'm not --
THE COURT: Slow down for the court reporter, please.
Diabetic peripheral neuropathy.
THE WITNESS: Yes.
BY MR. NOLAN:

Q. OK. Do you know whether it's FDA-approved for diabetic peripheral neuropathy or not?
A. Not with 100 percent certainty.
Q. OK. Do you know whether it was at the time you issued your report?
A. I don't recall.
Q. OK. Gabapentin, fair to say it's potentially addictive, right?
A. Theoretically, there's a very minimal risk, yes.
Q. And you said it works by essentially binding to the calcium channels in your spinal cord; is that fair?
A. Yes.
Q. Same way as Lyrica works?
A. Yes.
Q. And you said there's potential for it to be addictive, but there's also potential for it to be abused, right -- gabapentin?
A. Yeah. I mean really anything could be abused.
Q. And to be clear, gabapentin and Lyrica are both known as gabapentinoids; is that fair?
A. Yes.
Q. And can you just explain what does -- is that a class of drugs -- gabapentinoids?
A. Yes.
Q. And with respect to the potential for abusing them, is

that -- can that be exacerbated if a person has a history of addiction?

A. Well, the risk -- you know, the risk of addiction increases if someone has a risk -- a history of addiction.

Q. OK. What if they are also using, a person's also using opioid therapies?

A. Correct. It would increase the risk.

Q. OK. And so is there a risk with, when a patient uses gabapentin also with alcohol?

A. Yes.

Q. And what's that risk?

A. I don't know if anyone knows the specific, quantifiable number, but the risk increases.

Q. OK. And how about using them in combination with CNS depressants?

A. And what's the question with regard to that?

Q. CNS depressants, central nervous system drugs.

A. Yes. What's your question, though?

Q. Is there any risk posed by using gabapentinoids with those?

A. Yes, there are risks.

Q. Does gabapentin or gabapentinoids generally, do they have -- are they commonly indicated with respect to other medications? Are there any that you can name that you think it shouldn't be mixed with?

THE COURT: Counsel, one question at a time.

MR. NOLAN: Yeah.

THE COURT: Which one do you want?

BY MR. NOLAN:

Q. Are there any medicines that, other pain medications or pain medications at all that you're aware of that shouldn't mix with gabapentinoids?

A. Yes.

Q. OK. What are those?

A. Well, I think just in a basic form, it's not generally a good practice to have someone on both gabapentin and Lyrica, for instance. In addition, other central nervous system antiepileptic agents would also be generally not best practice.

Q. You cite in your report, if you look at the bottom, there's a number of footnotes to various articles, authorities, publications. Is that fair?

A. Yes.

Q. OK. You consider those part of your report?

A. The references? Yes. I mean they're referenced out to those reports, yeah.

Q. Are those reliable sources?

A. Generally, yes.

Q. And did you rely on them in preparing your report?

A. Only so much as it was to make a particular point or to reference a particular, whatever I was referencing.

Q. And the sources that you relied on, the publications were

reliable sources?
A. Yes.
Q. I want to bring your attention, very briefly, to -- I believe it's footnote 4.
A. What page are you on?
Q. It's on page 6.
A. OK.
Q. Talks about a -- there's a reference to a Goodman CW, Brett AS. Do you know who that refers to? Is that an author?
A. Are you asking me if I know the author?
Q. Do you know who it is that authored that publication?
A. Well, it's referenced there, but I don't know who that person is.
Q. OK. But the publication that you relied on is a clinical overview of off-label use of gabapentinoid drugs. Is that fair?
A. Yes.
Q. OK. And you said -- and that would be a reliable article; is that fair?
A. For the point I'm making, yes.
MR. NOLAN: OK. I'm going to read from that article, under F.R.E. 803(18), your Honor.
THE COURT: I have it memorized.
MS. AGNEW: Your Honor, I'd also ask for a copy, please.

MR. NOLAN: Sure.

MS. AGNEW: Thank you. He should get a copy.

MR. NOLAN: Who should get a copy? Are you talking about the witness? Well, he doesn't need it.

MS. AGNEW: Do you have another copy?

MR. NOLAN: Do you want to enter it into evidence?

MS. AGNEW: No. I'm asking you if you have another copy.

MR. NOLAN: I do. I have two more copies.

MS. AGNEW: Then why can't he see it?

MR. NOLAN: Well, I guess he can.

THE COURT: Are you people talking off the record, or what?

MS. AGNEW: Sorry.

MR. NOLAN: Sorry.

THE COURT: If you're going to talk off the record, use your off-the-record voices.

BY MR. NOLAN:

Q. I'm going to show you, Dr. Carinci, an exhibit that's marked as D28. I hand marked it.

A. Thank you.

Q. And have you taken a look at exhibit D28?

A. I mean I haven't read through it, but yes, I -- this is familiar to me.

Q. And that is, in fact, the article that is referenced in

footnote 4 of your report; fair?

A. Yes.

Q. OK. And I'm just going to read through portions of it with you. If you can look at the second page, on the right-hand side, about halfway down, there is a paragraph that starts with "several findings are noteworthy." Do you see that?

A. Yes.

Q. OK. It says: "First, for gabapentin treatment of painful diabetic neuropathy (a common condition for which gabapentin is prescribed off-label), the evidence is mixed at best. Among five trials, two (including the largest and longest-duration trial) showed no benefit, and two showed improvement of only about one point on zero to ten scales compared with placebo." Do you see that?

A. I do.

Q. OK. If you go to the next sentence, it says, "A recent Cochrane review estimated that roughly six patients with painful diabetic neuropathy would require treatment with gabapentin to provide 'substantial benefit' for one patient." Do you see that?

A. Yes.

Q. OK. And then it says: "Second, there were few studies of gabapentinoids for nondiabetic neuropathies; studies were either negative or yielded statistically significant mean differences less than one point on zero to ten scales compared

with placebo." Do you see that?
A. Yes.
Q. OK. The next paragraph down, it says, "Third, the evidence does not support gabapentinoid therapy for low back pain or radiculopathy." Do you see that?
A. Yes.
Q. And then it says, "In the largest study (a placebo-controlled trial of pregabalin for sciatica), the drug was ineffective." Do you see that?
A. Yes.
THE COURT: Slow down.
BY MR. NOLAN:
Q. OK. And then if you look at the next page, there's a statement at the top. It says, "table 1, randomized clinical trials of gabapentin versus placebo for off-label treatment of pain." Do you see that?
A. Yes.
Q. And then the first, under clinical condition, it lists a test, it lists diabetic neuropathy, a trial for that. Do you see it?
A. I do.
Q. And it says 421 participants. Do you see that?
A. Yes.
Q. And for 12-week duration, there was no benefit in the difference in pain compared with the placebo. Do you see that?

A. Yes.
Q. Now, if you look at the bottom of the article, the bottom right, the first -- the paragraph at the bottom right, it says, "Fifth, both gabapentin and pregabalin are FDA-approved for treatment of postherpetic neuralgia." Do you know what postherpetic neuralgia is?
A. Yes.
Q. What is it?
A. Postherpetic neuralgia is essentially a neuropathic pain condition that results after an acute herpes zoster infection.
Q. OK. And doesn't have anything to do with diabetic neuropathy?
A. What was your question?
Q. It's not related to diabetic neuropathy, is it?
A. It's not related to it, no.
Q. Right. And does that refresh your recollection as to what the gabapentinoids are approved for by the FDA?
A. Does this article refresh my --
Q. No. That statement right there.
A. Yes.
Q. And then would you go to the next page, sir; there's a paragraph on the bottom left. It starts with "sixth." Do you see that?
A. I do.
Q. It says: "Tables 1 and 2 summarize that a small number of

placebo-controlled gabapentinoid trials have been performed for various other pain syndromes. With few exceptions, the drugs were either ineffective or associated with small analgesic effects that were statistically significant but of questionable clinical importance." Do you see that?

A. Yes.

Q. If you go to the next page, under -- there's a column that says the language of review articles and guidelines involving gabapentinoids. About halfway through the first paragraph, there's a sentence starting with "Neuropathic pain." See that?

A. Yes.

Q. It says, "Neuropathic pain is defined by the International Association for the Study of Pain as '[p]ain caused by a lesion or disease of the somatosensory nervous system.'"

Is that an accurate description of neuropathic pain?

A. It's reasonably, yes.

Q. Then it says, "Many clinicians likely conceptualize neuropathic pain in a similarly nonspecific way that includes conditions ranging from localized anatomical pathology *(e.g.*, nerve root compression from disc herniation) to systemic disorders with neuropathic effects *(e.g.*, diabetes)." Do you see that?

A. I do.

Q. OK. And then to the right, there's a column, says adverse effects and misuse. Do you see that?

A. Yes.
Q. It also says that "Meta-analyses consistently show a substantial incidence of dizziness, somnolence and gait disturbance in patients who take gabapentinoids, with dose-dependent effects." Would you agree with that?
A. Yes. Depends, but yes.
Q. And then it says, next paragraph down, first sentence: "Evidence of misuse of gabapentinoids is accumulating and likely related to the opioid epidemic. A recent review article reported an overall population prevalence of gabapentinoid 'misuse and abuse' as high as 1 percent, with substantially higher prevalence noted among patients with opioid-use disorders." See that?
A. I do.
Q. "The higher prevalence among patients with opioid-use disorders may relate to the reported augmentation of euphoria." Do you agree with that?
A. Yes, in some instances.
Q. And then the next sentence, it says, "This trend is troubling, particularly because concomitant use of opioids and gabapentinoids is associated with increased odds of opioid-related death." Do you agree with that?
A. No, not particularly.
Q. OK. But this is an article you cited and put in your report?

A. Let me clarify my point of view. I think it depends is what I'll say there.

Q. OK.

A. Depends.

Q. Then the next paragraph says, "Reports from law enforcement agencies corroborate growing diversion activity and street value for gabapentinoids." Do you agree with that?

A. I don't dispute it.

Q. You don't?

A. Have not seen it in clinical practice personally.

Q. OK. And the next page, under conclusions, it says: "The evidence to support off-label gabapentinoid use for most painful clinical conditions is limited. For some conditions, no well-performed controlled trials exist. For others, one or several placebo-controlled studies have been published, but results have generally shown the drugs to be either ineffective or only modestly and inconsistently effective." Do you see that?

A. Yes.

Q. OK. And just to be clear, this is an article you used in support of your own report; fair?

A. Yes, it is.

Q. Thank you.

I want to ask a little bit about tramadol. That's mentioned in your report a few times, but I think you used the

word Ultram?

A. Yes.

Q. Is that the commercial name?

A. Yes.

Q. Is that a drug that's meant to be taken routinely?

A. It depends.

Q. You typically would not prescribe it in a manner that's used on a day-to-day basis, would you?

A. No, that's not true.

Q. You would typically -- don't you consider it an abortive medication?

A. In some instances, yes. But in others, no.

Q. OK. I'll come back to that.

On page 11 of your report, you refer to a patient named James Allen. See that?

A. Yes.

Q. You refer to a drug called Tegretol?

A. Yes.

Q. Is that an anticonvulsant drug?

A. Yes.

Q. Is that sort of like an antiseizure drug?

A. Yes.

Q. OK. And does it also go by the name carbamazepine?

A. Yes.

Q. And is that ever used to treat pain?

A. It is.
Q. Is it ever used to treat nerve pain?
A. It is. It's like a third-line agent.
Q. OK. At page 12 of your report, there's a reference to a Frank Andolina?
A. Yes.
Q. It refers to -- there's a reference to Suboxone. What is Suboxone?
A. Suboxone is an opioid class of medications that is generally prescribed for people that have an opioid-abuse disorder.
Q. And is it -- what is it made of?
A. Buprenorphine is the main ingredient.
Q. Is buprenorphine an opioid?
A. It is.
Q. And is it for -- it's used to treat addiction; is that fair?
A. It is used to treat addiction. It is also used to treat pain.
THE COURT: Doctor, would you spell what the drug is made from; what is it its main ingredient?
THE WITNESS: Buprenorphine, B-U-P-E-N.
MS. AGNEW: I think it's on our list, your Honor.
THE WITNESS: This is a lot of pressure.
THE COURT: Anyway, somebody give it to the court

reporter eventually.

BY MR. NOLAN:

Q. All right. You said it's used to treat -- are you saying Suboxone is used to treat pain?

A. Yes.

Q. Is that frequent?

A. It's increasingly used in that instance.

Q. Does it work well for pain?

A. Yes.

Q. Do you prescribe it for pain?

A. I have in the past.

Q. Any of your patients responded well when you do?

A. Some have and some have not.

Q. Is it -- in addition to treating pain, does Suboxone also -- is it used to treat active addiction?

A. It can.

Q. OK. And chronic pain and addiction have many shared patterns, correct?

A. They do.

Q. Those are neuropsychological patterns?

A. Yes.

Q. And the presence of active addiction complicates the care of chronic pain patients, right?

A. It does.

Q. And treating patients with active addictions with

medications that have abuse potential is not something that is advised, is it?

A. Generally not.

THE COURT: Wait for just a minute.

OK.

BY MR. NOLAN:

Q. OK. And in your practice, you have had patients who demand specific medications, right?

A. Sometimes, yes.

Q. Are there times when you refuse to give it to them?

A. Yes.

Q. Even when they're telling you it helps for their pain?

A. Yes.

Q. Why is that?

A. Well, I think it depends. It depends on what particular medication they're asking for. It depends on their medical history. It depends on their medical contraindications. I think there's a lot that goes into that assessment.

Q. So just because a patient tells you it worked for their pain doesn't necessarily mean that it's right for them, right?

A. Correct.

Q. That could be true with any drug, right?

A. Possibly.

Q. Any pain medication?

A. Possibly, yes.

Q. Have you ever given in and prescribed a drug that you thought was inappropriate?
A. No.
Q. You wouldn't expect other providers to prescribe medications that they thought were inappropriate for a patient, would you?
A. No. I would just ask that they document their rationale.
Q. OK. And in cases where you refused to provide the drug of choice to the patient, do you offer them alternatives?
A. Yes.
Q. OK. What are some of those alternatives?
A. Well, I mean it depends. It depends what they're asking for and it depends what their medical condition is, and it's -- I don't think you can answer the question without knowing more about the particular patient and request.
Q. Do you ever offer nonmedication alternatives?
A. Yes.
Q. OK. What types?
A. Well, physical therapy, chiropractic therapy, TENS units, you know, injections or procedures.
Q. All of those are things that can be used to treat pain?
A. Yes.
Q. And if the patient doesn't want those alternatives, then there's really nothing more that you can do for them, right?
A. I think it depends. Depends how willing they are to try

something that they've, they may not initially be open to. Depends on the patient. Depends on the situation.

Q. When a patient comes to you and wants a specific drug and you -- maybe you have your doubts, is there anything that you require them to do before you'll consider putting them on that drug?

A. Well, again, you know, we're just talking in such an abstract way, but I think depending upon the particular medication at issue, I would want to know for sure what their medical records, their prior history -- you know, if they're attesting that a particular drug is very helpful to them, I would like to see corroborative data in their medical record. Depending on the particular medication, we may necessitate a urine toxicology screen, a phone call with their prior treating doctor. I mean there's -- you know, it can get complicated.

Q. Have you had occasions in your practice where you found that a patient was abusing drugs?

A. Yes.

Q. OK. And when you've found that they were abusing drugs, do you typically wean them off or take them off the drug immediately? Sorry.

Do you typically take them off the drug?

A. It really depends upon the drug we're talking about and what particular infraction we're speaking of.

Q. Any case you've ever just stopped cold turkey prescribing

it?
A. Yes.
Q. You mentioned Elavil on your direct examination. Is that also known as amitriptyline?
A. Yes.
Q. That's considered by some to be a first-line medication for chronic pain, right?
A. Yes.
Q. And it can lessen pain severity?
A. Yes.
Q. And it can improve pain control, correct?
A. In some instances, yes.
Q. And it can result in improved function, correct?
A. In some instances, yes.
Q. All right. So we can agree it's a valid treatment for some patients with neuropathic pain, right?
A. Yes.
Q. And it's a valid treatment for some patients with chronic pain, right?
A. Yes.
Q. Is the same true with respect to Cymbalta?
A. Yes.
Q. Are you familiar with Sublocade?
A. No.
Q. OK. Is there an injection form of Suboxone that you're

aware of?

A. There may be.

Q. OK. You just don't prescribe it?

A. That's not something I would prescribe, no.

Q. OK. You've never heard of Sublocade?

A. No.

MR. NOLAN: No further questions.

THE COURT: Thank you.

Redirect examination, counsel.

REDIRECT EXAMINATION

BY MS. AGNEW:

Q. All right. Dr. Carinci, I'm going to direct your attention back to the exhibit that was premarked D27 by defense counsel.

MS. AGNEW: Was this entered into the record, counsel?

MR. NOLAN: No.

I'll move it into evidence, your Honor.

MS. AGNEW: We're happy to have it in evidence, your Honor.

THE COURT: Received.

(Defendants' Exhibit 28 received in evidence)

BY MS. AGNEW:

Q. Dr. Carinci, I want to look again at the last page of -- well, first of all -- strike that.

Can you look at your report, Dr. Carinci, where you cited this particular article, and I believe it was on page 6. And

what I'd ask you to do is just review that paragraph again, especially the middle section, to refresh your recollection on why you cited this particular article. Take your time.

A. Well, I cited this article in reference to the fact that gabapentin and Lyrica are widely prescribed for off-label pain syndromes, and they're frequently first-line alternatives for chronic pain, particularly when opioids are being weaned, withheld, withdrawn. And you know, whereas there may not be a hundred -- you know there's always conflicting studies. Some show efficacy. Some show no efficacy. Really depends on how the trials were designed. There's oftentimes not great clinical efficacy.

At the same time, we know with other patients that they may have no other alternatives, and we know that gabapentin is a relatively safe medication. It's generally well tolerated and does have effect on multiple different pain medications -- multiple different pain syndromes. So I was citing it in reference to the fact that it is being used off-label for many pain conditions despite the fact that there may be limited evidence.

Q. OK. And can you tell us the title of D --

MS. AGNEW: Is it 27 or 28? I am so sorry.

MR. NOLAN: Sorry. It's 28.

MS. AGNEW: OK.

MR. NOLAN: Did I say D27? If I did, it's D28 for the

record.

MS. AGNEW: OK. I apologize.

Q. D28, the title of D28 is the clinical overview of off-label use of gabapentinoid drugs. Can you tell us, Dr. Carinci, what is a clinical overview, in your experience?

A. A clinical overview is essentially a culmination of articles, you know, looking at efficacy of a particular outcome. And in this case, it's the off-labelled use of gabapentinoid drugs. And so the overview is meant to provide clinicians with essentially a summary of the thinking to date.

Q. And when you say thinking to date, are you indicating that this is a clinical summary of the trial data available to date?

A. Yes.

Q. OK. And in the section that Mr. Nolan read into the record, isn't it true it says, "for some conditions no well-performed controlled trials exist"?

A. Correct.

Q. OK. And then that same section of the article, which is the conclusion section, if you look at the last paragraph, probably the third sentence down, it says, "Judicious therapeutic trials of gabapentinoids are justified in patients with selected off-label pain syndromes when at least modest evidence of efficacy exists." Correct?

A. Yes.

Q. When you reviewed, sir, the records and you went and

examined those patients in order to publish your report, did you find evidence of efficacy existing in these patients with their prior treatment with gabapentinoids?

A. Yes.

Q. OK. And so would your opinion in this case actually comport very much with the conclusion of this article?

A. Yes.

Q. Can you tell me -- Mr. Nolan talked to you about Suboxone and in particular because one of these patients was on Suboxone. Correct?

A. Yes.

Q. And do you prescribe Suboxone to treat neuropathy in your patients?

A. I have.

Q. OK. And is it always a successful treatment for neuropathy?

A. No.

Q. If you had to, on any given patient, determine whether you would prescribe Suboxone for the treatment of neuropathy or a gabapentinoid, in your clinical experience, which would be your first-line treatment?

A. Gabapentin.

Q. And why is that, sir?

A. Safety, tolerability, efficacy are better with gabapentin in general.

Q. And is it possible if there is a patient who is already being treated with Suboxone for opioid addiction therapy that they might also need additional pharmaceutical treatment for severe diabetic neuropathy?

A. Yes.

Q. And why would that be?

A. Well, patients can have more than one pain issue. Patients can have overlapping problems, such as addiction and pain, like we talked about. And as we talked about early on, this morning, patients can respond differently to different medications, whereas some patients may respond to Suboxone for pain management, others may not. Some of them, patients may have -- Suboxone may actually be a good deterrent for opioid abuse. Others it may not. And so patients are individuals, and I'll just hearken back to that fact, that everyone responds differently to medications and when we find a medication that is efficacious, we're very careful in tapering it off.

Q. OK. And you also discussed with Mr. Nolan nonpharmaceutical treatments, correct?

A. Yes.

Q. OK. What is the goal when you prescribe a patient a nonpharmaceutical treatment?

A. Well, the goal is really multimodal therapy. Pardon me.

The goal is multimodal therapy, whereas a single agent or intervention may provide some relief, generally speaking, with

chronic pain, multimodal therapy tends to be synergistic in the sense that we can provide overall better analgesia with multiple routes of treatment.

Q. OK. And with those nonpharmaceutical treatments, would your goals be the same as if you were indeed tendering pharmaceutical treatment?

A. Would you ask the question again, please? I'm sorry.

Q. I will. That was confusing, and I apologize.

So, you reviewed the records of patients who, in fact, engaged in nonpharmaceutical treatments, correct?

A. Yes.

Q. In every one of those situations, did you find that the nonpharmaceutical treatments constituted effective pain management?

A. Well, in some instances they were effective. In others, no.

Q. OK. And so for any given patient, could you rely solely on nonpharmaceutical treatments?

A. No.

MS. AGNEW: I have no further questions, your Honor.

THE COURT: Thank you.

Recross, counsel.

MR. NOLAN: Nothing, your Honor.

THE COURT: Wonderful. You may step down, sir.

(Witness excused)

THE COURT: Is this a good time to break, friends?

MS. AGNEW: I think it is, your Honor.

(Luncheon recess)

AFTERNOON SESSION

2:04 p.m.

(In open court)

THE COURT: Good afternoon, folks. Won't you be seated.

Mr. Morrison.

MR. MORRISON: The plaintiff class will call Susan Mueller to the stand.

SUSAN MUELLER MD,

called as a witness by the Plaintiff,

having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MR. MORRISON:

Q. Good afternoon, Dr. Mueller. How are you doing?

A. Good afternoon.

Q. Just to start, can you please let us know where you are currently employed.

THE WITNESS: I have hearing problems, cochlear implants.

THE COURT: Yes, ma'am.

THE WITNESS: And——

THE COURT: Do you want them to speak up?

THE WITNESS: I have this little device that if he wears it, it will stream right into my devices. I'm having trouble hearing you.

(Discussion off the record)

BY MR. MORRISON:

Q. Dr. Mueller, can you start by you identifying where you currently work.

A. My office is at the Fishkill Correctional Facility in Beacon, New York.

Q. What position do you hold there?

A. Clinical physician III, regional medical director.

Q. Okay. And you're a regional medical director of what?

A. The Sullivan, Great Meadow, Oneida, and Watertown hubs.

Q. Okay. Can you explain what a hub is.

A. It's a grouping of correctional facilities——geographic grouping.

Q. Okay. So for each of those hubs——how many did you just mention; was it five?

A. Four.

Q. Four. For each of those hubs combined, how many correctional facilities do you oversee, for lack of a better word?

A. Good question.

Q. You don't know?

A. Honestly, I don't.

Q. Okay. How about an estimate?

A. Maybe about 15.

Q. And currently what are the duties and responsibilities of a

regional medical director for a hub?

A. We attend quality improvement meetings that are held quarterly in the facilities; we're a participant in mortality quality improvement meetings that occur when there's an unexpected death in a facility; we——when specialty referrals are made by the primary care physicians, if the outside reviewing agency denies the consult, then it's forwarded to the RMD for a review, for a final decision, one way or another; we serve as a resource to the facilities; any needs or questions, be it clinical or operational, they email or call us; sometimes we help train new employees. I'm kind of drawing a blank after that.

Q. That's okay. That's enough.

I think you've also testified before that you are a clinical supervisor of the physicians working in the facilities under your hubs; is that accurate?

A. Yes. In other words——yes, clinical. We're not their actual supervisor, but we are supervisory for clinical matters, yes.

Q. Okay. And it's also accurate that back starting in June of 2017 through February 8th of 2022, you also, as part of your responsibility, reviewed and were responsible for either approving or disapproving requests by providers to prescribe patients MWAP——M-W-A-P——prescriptions, is that it?

MS. THOMAS: Objection, leading.

A. Yes.

THE COURT: It's cross.

MS. THOMAS: No. This is his witness.

THE COURT: But isn't this an adverse witness?

MS. THOMAS: He hasn't established that she's a hostile witness.

THE COURT: And it is introductory.

THE WITNESS: I don't——was I supposed to hear that?

THE COURT: Yes. It doesn't matter.

THE WITNESS: Can you repeat? I don't know what was said. When I have it tuned in to you, I'm not hearing other things.

THE COURT: That was some legal talk.

BY MR. MORRISON:

Q. That was legal talk. You didn't need to hear that.

A. Oh, okay.

Q. When did you first become a regional medical director? And I'm going to use the acronym RMD, if that's okay. Do you understand what I mean?

A. Yes.

Q. Okay.

A. I'm——I think it was——it was either two thousand——the end of 2012 or 2013.

Q. And prior to that what were you doing; where were you working?

A. I was the facility health service director at Wallkill Correctional.

Q. And as facility health service director at Wallkill Correctional Facility, did you provide direct patient care?

A. Yes, I was the only provider there. There were no others.

Q. Okay. And when you became an RMD, would you consider that a promotion when you became an RMD?

A. It was a promotion, but we made less money.

Q. Doesn't sound like a promotion to me.

A. And worse benefits. Yeah.

Q. When you became an RMD, did you continue to provide direct patient care to patients in custody of the New York State Department of Corrections?

A. No.

Q. So is it fair to say that you haven't provided any direct patient care to any incarcerated individual since your promotion?

A. That's correct.

Q. Other than Wallkill Correctional Facility, were you working as a physician in any other correctional facility during your time at DOCCS?

A. Yes.

Q. What other correctional facility?

A. Shawangunk and Sullivan.

Q. Sullivan was the first correctional facility you began

working at?
A. Yes.
Q. What year was that?
MS. THOMAS: I believe it was 1993.
Q. And during your time——and then you went to Shawangunk.
A. Yes.
Q. And were you the facility health service director at Shawangunk?
A. Yes.
Q. And is it accurate that you were also the only medical provider at Shawangunk when you were there?
A. Yes.
Q. During your time providing direct patient care at Sullivan, Shawangunk, and Wallkill, did you prescribe medication to your patients?
A. Yes.
Q. And in prescribing medications, did you ever have to submit any form to any regional medical director or any supervisor above you to be allowed to prescribe that medication to a patient?
A. Yes.
Q. And under what circumstances did you have to submit paperwork to get approval?
A. For any nonformulary medication.
Q. And can you explain what a nonformulary medication was, or

is.

A. Pharmacies, be it hospitals or insurance companies, whatnot, have certain medications that they keep on formulary. They are the medications they would prefer you prescribe because that's what they have. You can't have every medication in a certain class on formulary, so to speak.

Q. Okay. In regards to pain medication back when you were working as a direct care provider, do you recall what classes or types of medications were considered nonformulary?

A. I don't think that there is——there's always something in a class that's formulary, so I'm not quite understanding the question.

Q. That's fair. It was a bad question.

Was Neurontin, back when you were a direct care provider, a formulary or nonformulary drug?

A. I believe it was formulary.

Q. Was it your practice——or strike that.

While you were providing direct patient care did you ever prescribe any patient Neurontin?

A. I don't remember.

Q. Okay. Do you have any——strike that.

Can you describe briefly your medical education and background.

A. You mean where I went to medical school?

Q. Yeah.

A. I went to New York Medical College. I was a physical therapist for several years, then due to exposures and whatnot, I decided I wanted to go to medical school. And then I completed a residency in general surgery.

Q. What year was that?

A. 1990.

Q. And after your residency did you practice?

A. Yes.

Q. Where?

A. In Georgia, and in Liberty, New York, and in Newburgh, New York.

Q. And what type of medicine did you practice?

A. General surgery.

Q. Do you have any board certifications?

A. I was board certified in general surgery, but when you're due for recert, part of the process has to be your operative log, and since I no longer operate, my certification has expired.

Q. Okay. So when did your certification expire?

A. I don't know.

Q. Was it before the time that you became an RMD?

A. Yes. I——I believe so.

Q. Did you ever get any specialty training or certifications in pain management?

A. No.

Q. And it's true, as you sit here today, you don't consider yourself an expert in anything, right?
A. I don't really know what that question means.
Q. Well, do you remember taking a deposition in July 28, 2023?
A. Yes.
Q. With a court reporter there?
A. Yes.
Q. And you were sworn to tell the truth?
A. Yes.
Q. Do you remember being asked these questions and providing this answer:

MS. KILEY: Could you give us the page and line number, please.

MR. MORRISON: It's page 54, line 24.

Q. "Q. Would you consider yourself an expert in anything?" Mr. Ramage, your attorney, objected. Your answer: "No."

Do you remember being asked that question and you provided that answer?

A. You've just refreshed my memory. Thank you.
Q. Okay. So would you agree that as you sit here today, you don't consider yourself an expert in anything?
A. I guess officially speaking, yes.
Q. Okay. I want to direct your attention right to it, back to 2015, okay? And you were an RMD in 2015, right?
A. Yes.

Q. And do you remember being asked to participate in something called the narcotics review committee?

A. Are you referring to the Green Haven?

Q. I am.

A. Oh, yes.

Q. Okay.

A. I didn't know it by that name.

Q. What name did you know it by?

A. I guess I don't really remember any particular name, but yes.

Q. Okay. How did you come to learn that you——strike that.

How were you asked to participate in the narcotics review committee?

A. I believe the CMO asked me.

Q. And who was the CMO at the time?

A. Dr. Koenigsmann.

Q. And can you describe what the narcotics review committee was.

A. There were three——three RMDs; and the facility health service director——this is at Green Haven——I think a pain medication nurse; Dr. Weinstein, a physiatrist. I'm not sure who else might have been on the committee. It's quite awhile ago. And per the direction of the then-commissioner, they wanted us to review the patients who were on narcotics and Neurontin because at the time the facility was crippled with

medication lines that were running all day and in several locations throughout the facility programs couldn't run, etc., etc., is how it was explained to me, so every patient who was on any of these identified substances, medications, was presented to the committee by their primary care provider; their case was presented.

Q. Okay. So it's your understanding that this committee was formed because Green Haven was being crippled with long medication lines that was affecting programmings and things like that.

A. That's what I was told.

Q. Okay. Who told you that?

A. I don't know if it was Dr. Koenigsmann, the superintendent at the time? I don't recall exactly who told me, but those would be my guesses.

Q. When you became part of this committee, were you provided any data in regards to the amount of medications or narcotics that were being prescribed at Green Haven?

A. No, but I wasn't the, shall we say, the head of the committee. The RMD who was might have been.

Q. And who was that?

A. That was Dr. Bailey-Wallace. Green Haven was actually one of her facilities.

Q. Was it your understanding during the committee that the purpose was to review all the patients that are on narcotics

and try to see which ones you can get off?
A. Well, if that was a possibility.
Q. Okay. And isn't it also true that in addition to narcotic medications, you were also tasked with reviewing every prescription of Neurontin that was in Green Haven?
A. Yes.
Q. And how often as part of this committee would you go about these presentations at Green Haven?
A. Weekly.
Q. For how long?
A. Months.
Q. And can you describe to the Court these presentations and how they went about. Did that make sense?
A. I don't know.
Q. Okay. So can you describe the presentations that were presented to the committee at Green Haven.
A. The provider whose patient was being presented——we sat in a room with a big table——would come in, would have the patient's chart, and would present the patient to the committee, and then a discussion would ensue.
Q. During these presentations were you and other committee members allowed to ask questions to the provider about the patient?
A. Yes.
Q. During these committee meetings with the presentation, was

the patient itself, himself, ever brought in and asked any questions?

A. No.

Q. Any reason why that didn't happen?

A. The provider met with the patient prior to and after each of these meetings. As to why they weren't brought in, I don't have the answer to that.

Q. And as a result——do you know roughly how many patients and how many reviews occurred?

A. No. Dr. Bailey-Wallace would probably——would have had that information because she was tasked with each week sending——making and sending a report to the commissioner.

Q. Okay. Each day or once a week when you went to Green Haven and did these presentations, roughly how many presentations were done?

A. I don't know.

Q. Prior to starting were you provided any data——strike that. I've already asked that.

As a result of the narcotics review committee, would you agree that numerous patients at Green Haven were discontinued from medications that they were previously on?

A. I honestly don't know. I wasn't tracking it.

Q. Okay. If you can take a look, there should be a document that's marked Exhibit 138.

A. That's not in this book, is it?

Q. No. It's right to your——

THE COURT: It's on the side bar right next to you on your left, ma'am. Yes, ma'am.

A. Sorry.

Q. No problem.

Dr. Mueller, if you can take a moment and just flip through this document quickly. And let me know if you recognize it.

A. No, I never saw this.

Q. Okay. Well, do you remember seeing it at your deposition?

A. Oh, at the deposition? Yes.

Q. Okay.

A. Sorry.

Q. And do you remember discussing it and this being a printout or a chart of meeting dates and inmates that were reviewed?

A. I recognize it as such.

Q. Okay. And it looks like we have——don't worry. I'm not going to go through each meeting.

But on the first page up at the top, it says 4/15/2015. The next page, 4/21/2015 date.

A. Yes.

Q. And this reflects those patients that were reviewed on each meeting date for those dates; would you agree?

A. It would appear as such.

Q. Okay. And without going——well, going through the chart, the sixth column has medications, and it lists the medications

that are associated with each inmate, correct?
A. Yes.
Q. And then on the column to the right of that, it says Final D/C Date, right?
A. Yes.
Q. What does D/C mean to you?
A. Discontinue.
Q. Okay. And in this first page, there are 16 inmates——correct?——listed.
A. Oh, the first page. I'm on the second. Sorry.
Yes.
Q. And of these 16 inmates, all but one have a final discontinue date for the medications associated with them; is that accurate?
A. Which is the one?
Q. Looks like No. 4, Baez?
A. Okay. Yes.
Q. And this would reflect that each 15 of the 16 patients that were discussed on April 15, 2015, resulted in a final discontinuation date for their medication. Would you agree with that?
A. Yes.
Q. Okay. And if you flip to the next page.
For April 21, 2015, there's 15 patients listed, two of them discussed during the meeting; is that accurate?

A. Yes.
Q. And of those 15 patients, if you look to the final discontinue date column, it looks like there are only two that do not have a final discontinuation date listed; is that accurate?
A. I'm still looking.
Q. Sure. And I'll direct your attention to Boone, No. 2, and Ruiz, No. 12.
A. Well, I'm seeing on No. 3, it says, "Keep Neurontin," "Keep Neurontin, MS Contin" on No. 3.
Q. There in the comment section?
A. No. 1, it says, "Keep Neurontin"; No. 3, "Keep Neurontin and MS Contin," yes.
Q. Okay. Fair. No. 6, to be fair, says "Keep Neurontin" as well, right?
A. No. 6. I haven't gotten any further.
Q. Okay.
A. Okay.
Q. So but it's true——strike that.
Looking at just these first two meeting dates, does it look to you that the majority of the individuals that were discussed in the presentations did result in the discontinuation of their medications?
A. Yes.
Q. And instead of going over each page, if you want to turn to

the last page of this exhibit, which is marked 138, it has a chart breakdown, first column having meeting dates, the second column discontinued date, or discontinued, the next column weaning. What does weaning mean?

A. Tapering a dose, lowering.

Q. Okay. Does it mean tapering and lowering till taking them off?

A. Usually it does.

Q. Okay. And then it says keep, which, do you know what keep means?

A. Continue the medication.

Q. Okay. And the total at the bottom has 196 discontinued, 4 weaning, 11 keep, correct?

A. Yes.

Q. Now looking at this document, and this breakdown, would you agree that the majority of the individuals that were reviewed from April 15, 2015, to June 9, 2015, were discontinued from their medication?

A. Yes. And it should be noted that word gets out in facilities pretty quickly when something's going on, and a lot of——we were told that quite a few of the incarcerated individuals who were on these medications were coming to their providers proactively and saying "Take me off of it," because in reality, they weren't taking the medication themselves, they were being hit up——upon by other incarcerated individuals for

the drug.

Q. Do you have any documentation to support what you just stated?

A. No.

Q. Where did you learn this information from?

A. From the primary care providers there at Green Haven.

Q. Okay. You never——none of these patients that you allege stated to the provider that they wanted to be taken off this medication told this to you.

A. No. I didn't speak to any of the patients, so this was not direct——a patient did not speak to me, no. It was their provider relaying the information.

Q. And according to you, you learned this information during the provider's presentation?

A. Yes.

Q. Okay. Which provider told you that?

A. Oh, I think it was——it might have been all of them. There were——a lot of the incarcerated individuals who had been on these medications had been on them for a long time, and the providers weren't even seeing them. It was just automatic renewals without seeing the patient.

Q. So if the provider wasn't ever seeing the patients, how did the patient inform the provider that they wanted to get off their medication?

A. Because when the word got out that this——all of the cases

were being reviewed and whatnot, they came proactively and said, "Take me off of it."

Q. Well, isn't it also accurate that patients at Green Haven or any facility aren't forced to take medication?

A. They weren't taking it themselves. It was being——they were obtaining it for the other incarcerated individual who was pressuring them to get the medication to divert it to him.

Q. Which patient did this occur to?

A. Oh, I don't know. I'm sorry.

Q. Okay. So would you agree that as a result of the narcotics review committee, the lines at Green Haven in regards to medication decreased?

A. I don't know.

Q. Did you ever come to learn any positive or negative response from the commissioner's office in regards to the narcotic review committee's work?

A. No, because I wasn't the RMD in charge, so any communication was between that RMD and the commissioner.

Q. Were you, as part of the narcotics review committee, ever part of reviewing or creating a final report for the commissioner?

A. No.

Q. And do you consider the narcotics review committee to be a successful endeavor?

A. According to their superintendent and even some of the

providers who were involved, they felt that it was.
Q. And do you feel like the narcotics review committee was a successful endeavor?
A. Well, if the people that were working there felt it was, by virtue of that, I guess I would say it was.
Q. Did you have any communication or have you ever spoken to any of the patients who were subject to the narcotics review committee's presentations who lost their medication, of whether they believed it was successful?
A. No.
Q. After——let me ask you this: So after the presentation how did the determination from the narcotics review committee of whether to discontinue or continue medication occur?
A. Could you repeat that.
Q. Sure. Following the presentation of the provider, he comes in, he has his, or her——has the chart of the patient, questions are asked back and forth regarding the patient's medications. How did it come——how did the committee make their determination of whether the patient should continue on the medication or be discontinued?
A. It was a group discussion.
Q. Pardon?
A. It was a group discussion and determination.
Q. Was the provider involved in the group discussion or was it——

A. Yes.
Q. Okay. And how long did those group discussions occur?
A. How long did it——
Q. Yeah.
A. I can't tell you that.
Q. Were they short, ten minutes, five minutes, 30 seconds?
A. It all depended on the case.
Q. Okay. And what type of issues were discussed?
A. What treatments had been, you know——what kind of testing might have been done for that particular incarcerated individual; what treatments had the incarcerated individual undergone——physical therapy, perhaps pain management injections, orthopedic or neurology, neurosurgery, consultations, different——what other medications had been trialed.
Q. How about the effectiveness that the medication has on the patient?
A. You just went——okay. You went dead.
Q. Sorry. Is it working?
A. Yes.
Q. Okay. Was the effectiveness of the medication on the patient discussed during the determination?
A. Yes.
Q. And if the medication was effective in treating the pain of the patient, did you keep the patient on the medication?

A. I don't——I can't——I can't really answer that because each case was different.

Q. Okay. Well, under what circumstances where the discussion resulted that the patient was being effectively treated by the medication would result in that medication being discontinued?

A. Hypothetically an example could be where some diagnostics needed to be performed to see if there would be a more effective treatment for the patient, or in some of these cases the provider themself might have said, I don't think that he needs this. This wasn't a one-sided determination or decision. The provider was part of the decision-making process.

Q. Okay. Well, was there ultimately a vote? What happens if one person on the committee thought that he should keep the medication, another person thought he shouldn't keep the medication?

A. I guess you need a tiebreaker. I'm not trying to be——

Q. A typewriter?

THE COURT: Tiebreaker.

A. Tiebreaker. But I'm not trying to be smart, you know, or disrespectful.

Q. Okay. No, no, no. That actually helps me.

So there was a vote after the discussion.

A. I don't recall formal votes, just discussions, and then everybody would seem to come——in my recollection, seem to come to the same consensus.

Q. Okay. And all of these discussions were done outside of the presence of the patient himself, right?
A. Yes.
Q. And you mentioned something in regards to if the proper testing wasn't done for a patient that the medication would be discontinued until that testing was completed; is that accurate?
A. I think that's why some of them might have had, you know, "Keep Neurontin" or whatnot, while things were pending.
Q. Okay. Because you would agree that discontinuing a medication because proper testing wasn't done or in the file would not be appropriate if that medication was effective for the patient.
A. Yes.
Q. To your knowledge was the narcotics review committee ever instituted in any other correctional facility?
A. Not to my knowledge.
Q. In any of your correctional facilities did you ever do an independent review of the amount of prescription narcotic drugs or Neurontin being prescribed?
A. No.
Q. Did you ever have a concern about the amount of Neurontin or prescription drugs being prescribed?
A. The——in some facilities, SURNs——which are senior utilization review nurses——had done audits, and thought that

there was an excess number——not excess——too high a number of patients receiving Neurontin, but that wasn't RMD directed and it wasn't at all facilities.

Q. As the clinical supervisor, an RMD, of the facilities and the providers, you never were concerned about the amount of narcotics or Neurontin medications being prescribed; is that accurate?

A. Not in my role as an RMD, no.

Q. You didn't think that——

THE COURT: No, you were not concerned?

Repeat my question.

Q. "No, you were not concerned?"

A. If it was brought to my attention. Sometimes there were——I can think of——I can think of one facility offhand where a SURN had completed a Neurontin audit and there was concern, and they made a QI project out of it.

Q. Okay. Before that SURN or indication to you that there was, they believed, a high amount of Neurontin being prescribed in that facility, did you have any concern?

A. No, because I would have no way of being aware of how much Neurontin was being prescribed in a facility.

Q. You never received any complaints from any provider or anyone regarding that before that SURN report.

A. Not that I recall.

Q. Okay. And you didn't take any action to try to reduce the

amount of prescriptions or the prescription habits of any provider before the SURN reports——would that be accurate?——in any of your facilities?

A. Correct.

Q. At some point in time——I want to move on to the MWAP policy, okay?

At some point in time you came to learn that a new policy was being formed, formulated in regards to how certain medications would be prescribed; is that accurate?

A. Yes.

Q. And that was called the MWAP policy, right?

A. Yes.

Q. Who, to your understanding, was charged with drafting that policy?

A. Dr. Dinello.

Q. Do you understand why Dr. Dinello was charged with drafting that policy?

A. I assumed it was because he was the head of the pharmacy and therapeutics committee and also because he worked on the outside in addiction medicine.

Q. Do you remember the first time you learned that this policy was starting to formulate within DOCCS?

A. Do you mean like a date?

Q. Roughly. Like 2016——how long after the narcotics review committee ended?

A. I don't know.
Q. Do you remember being involved in discussions about the formulation of that policy?
A. Not the specific formulation, but we had discussions at RMD meetings about perhaps having a policy created.
Q. Were you advocating for that policy?
A. Yes.
Q. Okay. And why were you advocating for that policy?
A. Because at the time, this was a time when the opioid epidemic was big-time national news, laws were changing with how prescription, you know, prescriptions can be written, and the SURN audits that were done were discovering what they thought to be overprescription of Neurontin, so yes, so I thought that maybe we needed to do something.
Q. Okay. You said laws were changing. Was it your determination that the prescriptions of medication within DOCCS by your providers were breaking laws?
A. Well, the DEA changed the law that you could only prescribe an opioid for three days for acute pain, so up until that point, yes, it was——they were being prescribed for longer than three days.
Q. Other than the three days of this new law that you allege occurred, any other laws that were being broken by your providers at DOCCS?
A. No, not that I'm aware.

Q. Was the issue in the SURN reports, to your understanding, about acute pain prescriptions or long-term prescription of narcotics and Neurontin medications?

A. They were long-term prescriptions.

Q. Did you see data in regards to your hubs about the amount of Neurontin medication or opioid medications being prescribed to patients?

A. I——I remember that when I was talking about the one facility where they brought up about the Neurontin, they had a report, so it had numbers.

Q. And when you saw those——what facility was that?

A. That was Greene.

Q. And what were the numbers that——were you disturbed by the numbers you saw?

A. I thought they seemed to be a little excessive.

Q. Okay. Were those numbers attached to any patients?

A. I don't recall.

Q. After you saw those numbers and you thought they were a little extreme, did you do any investigation in regards to why that many, those——that many prescriptions were being prescribed at Greene Correctional Facility?

A. The facility made a QI project out of it, and the facility, not with any of my involvement, met, I don't know how often. For argument's——I don't know how often, but I think they met weekly and discussed all the patients.

Q. Okay.
A. That was a facility committee, though, and I was not involved with it.
Q. Okay. It was a QI project? What's a QI project, just to be clear?
A. Quality improvement.
Q. And you had no involvement in the quality improvement?
A. Not in their QI, their Neurontin project, no.
Q. Okay. Tell me about the Neurontin project.
A. Not——their QI project, to evaluate their patients on Neurontin.
Q. Okay. And how were they evaluating the——
A. I didn't participate in the committee, so I——I don't know.
Q. You had no concerns about what was going on? I mean, you just saw the SURN report that you said had a disturbing amount of Neurontin prescriptions coming out of Greene. You weren't interested at all, you didn't think it was a bit important for you as the RMD to follow up?
A. Well, there was follow-up because they presented the findings of their committee meetings at the next QI meeting.
Q. Okay. But you weren't interested to be involved in that and find out how they were evaluating these patients at Greene, in prescriptions.
A. I was——it sounded to me, from what I was told by the facility, that they had a, again, several members of their

group, and they were presenting each case, probably similar to Green Haven, but I wasn't there so I can't say.

Q. You don't have any idea who was involved in this committee or group that was reviewing the prescriptions out at Greene?

A. I do know that the facility health service director, the nurse administrator, the deputy superintendent of administration, and I don't know about the superintendent or any other nurses. Those are who I do know.

Q. Why would the deputy superintendent of administration be involved in reviewing the medications of patients?

A. Because that person supervises medical units.

Q. Okay. Was that person a doctor?

A. No.

Q. Same thing with the superintendent. Why would a superintendent be involved in reviewing the prescription medications of patients in the facility?

A. I don't know if the superintendent was involved.

Q. Okay. And as a result of that committee, would you agree that Greene decreased the amount of Neurontin prescriptions being prescribed to patients?

A. My recollection is they did.

Q. And this all occurred before the MWAP policy came into effect; would you agree?

A. Yes. Yes.

Q. Do you know whether any of the patients involved in this

review were allowed to participate in the discussion and the review of their prescriptions?

A. I don't know.

Q. As the RMD, you also do peer reviews of each physician that works in your hub.

A. Yes.

Q. And you have been doing that since you became an RMD.

A. Yes.

Q. And I believe you testified before that that is——you take that role seriously, right, that job?

A. Doing peer reviews?

Q. Yes.

A. I take it seriously, but it has no impact.

Q. Right. Well, I know you go to the facility, you spend the day there, reviewing charts of a provider, right?

A. Yes.

Q. And then you go back to your office and you write the peer review.

A. Yes.

Q. At any point in time did you ever write a peer review for any doctor or nurse practitioner or provider criticizing them for the amount of prescription medications they provide to their patients?

A. No, and that's not part of the peer review.

Q. What's the peer review about?

A. It's checkmarks, when you are reading a chart, and theoretically it's supposed to be about chronic care appointments——for example, asthma——and there are certain things that you have to check and see, did they do. So it has nothing to do with prescription of narcotics, Neurontin, or anything else.

Q. Isn't it true, that's the first half of the peer review document and then there's another half where you can write a narrative?

A. You can write a narrative, and the narrative I write is in relation to the responses to those indicators.

Q. So in a narrative section of a peer review, it's true you've never criticized a provider working in one of your hubs for overprescribing medication.

A. I just don't address that.

Q. Okay. So you could address that if that was an issue, though; you could put that in the peer review.

A. Never thought to.

Q. Have you ever raised, made a complaint or an allegation to any provider during your time as an RMD that, you're overprescribing certain medications?

A. Did I ever make a complaint?

Q. Correct.

A. I don't think complaint would be the word, but when it got brought up, let's say, by an audit, I would speak to them about

it.

Q. Okay. Which audit and which provider are you speaking about?

A. Neurontin audit. I don't think there were any other audits that I——well, there weren't any that I was aware of.

Q. That was at Greene Correctional Facility.

A. Yes.

Q. And after that you brought it up with——what provider was at issue?

A. What? Which provider was it?

Q. Yeah.

A. Dr. Smith. I don't know——I don't remember who else was there then.

Q. What's Dr. Smith's first name?

A. Doreen.

Q. Doreen? And what were the numbers in regards to Doreen Smith's prescriptions of Neurontin that concerned you?

A. I don't know.

Q. How did you raise that issue to Dr. Smith after you determined that she was overprescribing or prescribing Neurontin in an excessive amount?

A. It was discussed at the QI meeting.

Q. Was Dr. Smith there?

A. Yes. It's the——it's the facility health director's meeting.

Q. Oh, she was the facility health service director at Greene.
A. Yes.
Q. And what did she——how did she respond to you informing her that you are troubled by the amount of Neurontin prescriptions she was providing to her patients?
A. Well, it wasn't me. It was the SURN giving the report.
Q. Okay. What did the SURN tell Dr. Smith?
A. I guess I really——this is a long time ago for me to remember specifics for you, so I can just surmise how it usually works at a QI meeting.
Q. Okay. Is it fair to say that after whatever the SURN report said and was presented to Dr. Smith, that she would have come away with the impression that she needs to reduce those prescriptions?
MS. THOMAS: I would just object to the extent it calls for someone else's impression, not Dr. Mueller's impression.
THE COURT: Okay. Would you ask the witness if she's able to answer the question.
MR. MORRISON: Sure.
BY MR. MORRISON:
Q. Did you understand that question and are you able to answer it?
A. Can you repeat it.
Q. Sure. Actually, let me rephrase it.

You were at that quarterly——that QI meeting where the SURNs informed Dr. Smith that they were concerned about the amount of Neurontin prescriptions; is that accurate?

A. I would assume I was, 'cause I go to most of them.

Q. Okay. And after you saw and heard the SURN informing Dr. Smith about this issue, were you under the impression that Dr. Smith should be reducing the amount of Neurontin prescriptions she was providing to patients?

A. What I——what I thought was, and what the——the members of the meeting decided was, that it warranted a QI project to take a look at——to take a look at the patients and the numbers.

Q. Okay. And was Dr. Smith involved in that QI, that Neurontin project from the QI meeting?

A. Yes.

Q. And as a result, did she reduce the prescriptions of Neurontin she was providing to patients?

A. I believe she did.

Q. Okay. And did you follow up after that in any way in regards to the effects that had on the patients that Neurontin prescriptions were discontinued?

A. No. That would have been Dr. Smith's doing.

Q. Okay. Was there any follow-up audit by SURNs in regards to the effects of the Neurontin project?

A. I don't know.

Q. Were you interested ever to find out the effects that the

Neurontin project had on the patients at Greene Correctional Facility that were prescribed Neurontin at one point?

A. Yes.

Q. And what did you do about those concerns?

A. Well, I——I can't say specifically. I would just be conjecturing that I speak with Dr. Smith, and she was never shy about voicing complaints about things she didn't agree with.

(Continued on next page)

BY MR. MORRISON:

Q. OK. And she didn't agree with the Neurontin project's results, correct; that's fair to say?

A. I had the impression that she was satisfied with the results.

Q. OK. So, after this Neurontin project at Greene, can you describe how the MWAP policies -- strike that. Terrible.

Can you describe your role in the creation or drafting or review of the MWAP policy before it was put into effect?

A. It was drafted by Dr. Dinello, and in my deposition, I believe he said that there were, you know, emails exchanged when he sent it around, does anybody have anything to say? And -- because I didn't have any real recollection of any.

Q. What was your understanding of what the MWAP policy was going to do in concerns with prescribing narcotic and Neurontin medication to patients?

A. The hope was that more time would be taken carefully evaluating patients and what treatment -- you know, what diagnostics may not, may or may not have been done that needed to be done, what other therapeutic options had been trialed or not, and to kind of have people take a closer look at their patients.

Q. It also involved the RMD taking control of whether Neurontin or MWAP medications could actually be prescribed by the provider to the patient?

A. Yes.
Q. Did you have any concerns about that part of the policy while it was being drafted?
A. I think while it was being drafted, I -- I was hoping that this was going to be, was hoping it was going to be a successful -- and when I say successful, I don't mean in discontinuing medications: I mean in seeing that a patient was getting the appropriate care.
Q. OK.
A. Too often -- too often prescriptions are written either without a patient being seen or just to get them out of the office without examining the patient and exploring, like I say, what really maybe needs to be done for this specific patient. And that can include diagnostics and other modalities, such as physical therapy, pain management.
Q. OK. So at around -- in 2016 and 2017, did you believe there was a rampant problem within DOCCS and its medical providers of not physically assessing their patients before prescribing or making prescription determinations?
A. I was having -- had a feeling that that was the case.
Q. And what was that feeling based on?
A. You get to know -- you get to know your providers, and you get -- you kind of know who is really taking the time with the patient. And it's more difficult and time-consuming, but you can take -- you know, you know that there are those that were,

but there also were those that weren't.
Q. And did you counsel those providers that you thought weren't taking care or seeing or assessing their patients about that?
A. Yes.
Q. And how -- how many providers did you counsel?
A. Oh, let's see. One, two -- it's hard for me to recall now. I'm just trying to -- I would be guessing if I said ten. I probably need more time to --
Q. OK. Roughly ten, maybe more, maybe less?
A. Maybe more.
Q. Maybe more.
And how many providers -- and at that time -- strike that.
Just to be clear, at that time, how many hubs were you the RMD over? I know it's not as many as today.
A. Two.
Q. Which ones were that, were they?
A. Sullivan and Great Meadow.
Q. And how many providers were you supervising or in those two hubs at that time, roughly?
A. 20.
Q. So about half?
A. But --
Q. Sorry.
A. But that's a really rough estimate.

Q. OK. So you believe it was about half of the providers at the time not providing and not conducting individual assessments of their patients before prescribing medication; is that accurate?
A. I know that I said that, but I would have to spend more time trying to think back as to who everybody was at the time.
Q. So when -- and at this time the MWAP policy is being formulated, discussions are going back with Dr. Dinello and yourself and other RMDs about formulating this policy, right?
A. Yes.
Q. And did you ever stop and say, you know, there's -- half of my providers are doing a fine job, why are we going to subject and take away their ability to prescribe medication without my approval? Did you ever bring that up?
A. No, but I think that they were going to do the job regardless, and they would most likely be prescribing things and providing information on the form supportive of their request.
Q. And which providers, just name -- if you can name three providers at the time that you felt were prescribing medications correctly, with assessments of their patients and no issues?
A. Oh, geez. Dr. Genovese. Dr. Makrim. Dr. Lavvio.
Q. Where was Dr. Genovese working; which facility?
A. She was at Wallkill.

Q. And Dr. Makrim?
A. Woodbourne.
Q. And the last one was -- I'm sorry. I wrote it down. I can't read my writing.
A. Lavvio.
Q. Lavvio. Where was --
A. Ulster.
Q. Now, we've identified three that you had no concerns about. Can you name me three that you were concerned about?
A. Dr. Lee.
Q. And where was Dr. Lee?
A. Shawangunk.
Dr. Andola.
Q. Where was Dr. Andola?
A. Eastern.
And -- I'm trying to think back to the facilities. Sorry.
I don't remember who was at Sullivan then. Doctor -- he was at Coxsackie. There were two of them there. He's been gone for quite a while.
Q. OK. That's OK. So Dr. Lee and Andola were two that you remember that you were concerned and had an issue with them overprescribing Neurontin and medications?
A. Dr. Miller at Coxsackie.
Q. To your knowledge, does Dr. Lee still work at -- for the Department of Corrections?

A. I believe he does not.
Q. Dr. Andola?
A. She left and just came back.
Q. Were you part of her hiring process when she returned?
A. No.
Q. How about Dr. Miller?
A. What?
Q. Is he still working at DOCCS -- he?
A. No.
Q. Is Dr. Miller a he or she?
A. He.
Q. So, upon learning, having these concerns, first, how -- what raised your concerns about these three providers specifically? Did you get data, or was it based on something else?
A. I don't get data.
Q. So is it fair to say while this, you were participating in it remotely, you weren't drafting it, you weren't doing what Dr. Dinello was doing, all of your recommendations and suggestions regarding the MWAP policy were all done based on no data? Is that fair?
A. I think the only recommendation that I made was to make sure he included about the three-day limit on a narcotic prescription for acute pain, because that had just come down from the DEA.

Q. OK. But that wasn't agreed upon, right? Because wasn't it a five-day emergency supply agreed upon?
A. Yes, but that didn't necessarily mean acute pain.
Q. OK. At any point in time, were you aware of whether a pain specialist doctor or someone with some sort of specialty in pain management was part of the process of creating the MWAP policy, which came to be known as policy 1.24?
A. I don't know if Dr. Dinello consulted with any pain management people.
Q. OK. Did you consult with any pain management people at any point in time about the policy?
A. No, I don't think so.
Q. How about when you were reviewing -- after the policy was implemented and you were reviewing medication requests, did you ever consult with any pain management specialists of whether you should approve or deny a prescription being presented to you?
A. I know there were times that I consulted with orthopedic surgeons and neurologists, but I don't specifically recall if I ever consulted with a pain management person.
Q. You would call -- strike that.
You would consult with orthopedic specialists or neurologists when you're determining to approve or deny an MWAP request?
A. Yeah -- yes.

Q. How would you do that?
A. It's by phone.
Q. OK. Which neurologist would you call on the phone?
A. Dr. Nancy Mueller.
Q. And Dr. Nancy Mueller is your sister, right?
A. Yes.
Q. How often would you call your sister, Dr. Mueller, regarding an MWAP request that was being presented to you?
A. I don't know.
Q. More than once?
A. Yes.
Q. OK. More than ten times?
A. Probably.
Q. OK. And when you had consulted with your sister, Dr. Mueller, about this, do you remember what was the ultimate conclusions? Would they be normally approved?
A. I don't recall.
Q. Under what circumstances would you want to consult with your sister, Dr. Mueller, in regards to an MWAP request?
A. I don't -- I don't remember what was going, what the requests were at the time, what was going through my mind. Might have been looking for some expertise that I don't have in the field or with medications.
Q. Because it's fair to say that you have never been and never held yourself out as an expert in what pain medication is good

for certain chronic pain conditions or neuropathies of patients?

A. Well, I think I have a pretty fair knowledge of what medications are indicated for neuropathies.

Q. OK. So -- oh. What -- you said it was, a neurologist would be your -- Dr. Nancy Mueller, who you would consult on times; and what was the other specialty? An orthopedic. What orthopedic would you --

A. Orthopedic surgeon.

Q. Who?

A. Dr. Francis Pflum.

Q. And who is Dr. Francis Pflum?

A. An orthopedic surgeon with specialty in spine.

Q. Does he have any position in DOCCS, or --

A. No.

Q. How do you know him?

A. From my work on the outside.

Q. A friend, colleague?

A. Colleague.

Q. And you would discuss MWAP requests and whether you should approve it or deny it?

A. I wouldn't be asking should I approve or deny this. I would be asking, you know, for additional information about what the, per the diagnosis was and if he had other management suggestions.

Q. Did your doctor -- your sister, Dr. Mueller, or Dr. Pflum say, you know, maybe it would be a good idea you should go see and talk to the patient?
A. I don't recall.
Q. Do you think it's a good idea whether to -- to determine whether to prescribe or not prescribe the medication for a patient to actually sit and speak with them?
A. In an ideal world, yes. But even with nonformulary medications, we never got to speak with or meet with the patient.
Q. Do you think it's a good idea to physically examine the patient before whether -- before you decide whether to approve or not approve a prescription medication for that patient?
A. I relied upon the physical examination conducted by the primary care physician.
Q. A physical examination that you didn't conduct?
A. That the primary care physician conducted.
Q. OK. Do you think it's appropriate to prescribe medication to -- or, strike that.

Do you think it's appropriate to determine whether a prescription should be provided to a patient when you never conducted a physical examination on the patient?

MS. THOMAS: Objection. This calls for expert testimony.

THE COURT: Counsel.

MR. MORRISON: It's her opinion, her belief.

THE COURT: Ask the witness is if she's able to answer the question, please.

MR. MORRISON: Sure.

Q. Are you able to answer that question?

A. The problem is the requesting primary care physician is tasked with performing a physical examination, and more times -- more often than not, they did not provide that. And that was where the problem lay.

Q. OK. So it's fair to say that you were, on many occasions, disapproving a primary care provider's request for Neurontin or an MWAP medication because the form didn't include the physical examination?

A. The physical examination and other information too that may have been pertinent to that request.

Q. OK.

A. And I would reach out to the requesting provider, either by email or phone, saying, you know, I need this information. And if they didn't furnish it, unfortunately, there was no pend option on the form. So it would end up having to be a denial, where if the information had been furnished, it very well could have been an approval.

Q. OK. So you would get a form that, to your determination, isn't complete to allow you to approve the medication, and you would pick up the phone and call the provider and tell him or

her what is incomplete in that form?
A. Yes. Either phone or email.
Q. OK. And when you're on the phone with the provider, can't the provider then just tell you what's -- what the information you needed?
A. I have to get the chart or I have to see the patient. No, they didn't necessarily -- they did not provide me with the information.
Q. Did they ever -- at no point in time you call and say I need the results of the physical exam and they'd say let me pull the chart and tell you what they are and then you can approve the medication?
A. If they provided it to me, yes.
Q. OK. And how often did that happen?
A. In my estimation -- well, I don't know.
Q. OK. So it's fair to say that if the form wasn't completed to the way that you wanted it to be completed, you would have to disapprove the medication?
A. Yes.
Q. And that was your practice. is that accurate, in reviewing MWAP requests from providers?
A. If you don't have the pertinent information, you can't make --
Q. And you understand by disapproving the medication means that that provider cannot get that medication from the pharmacy

for the patient?
A. When I disapproved a medication, I wrote comments, and it would be suggestions in absence of all of the information, suggestions of alternative treatments, modalities and whatnot that could be trialed.
Q. OK.
A. So it wasn't that the patient was being left without treatment.
Q. The patient was being left without the treatment that the provider was requesting; you would agree with that?
A. Without that medication, unless they resubmitted with the information that was necessary.
Q. Right. Well, I'm not talking about any resubmissions. I'm talking about the form that comes in that, according to you, isn't filled out properly so you have to not approve the medication. Right? You were aware that by saying not approved, that that provider couldn't provide that medication and prescribe that medication from the pharmacy to the patient?
A. Yes.
Q. And oftentimes, with these requests that you deemed were not properly completed were for renewals of prescriptions; would you agree with that?
A. I don't -- I don't really understand the question.
Q. All right. Well, let's -- you have a -- there's a big binder in front of you, which has been marked for the purposes

as Plaintiffs' Exhibit -- sorry -- 76, I believe.

MS. AGNEW: It's 76.

MR. MORRISON: Yeah, 76.

Q. Do you have that in front of you?

If you can turn to --

THE COURT: Counsel, would you ask the witness if the witness needs a break.

MR. MORRISON: Sure.

Do you need a moment? Do you need a break?

THE COURT: Tell us when you do.

MR. MORRISON: Yeah.

THE COURT: No, no. You're supposed to say that.

MR. MORRISON: Oh, tell us when you --

If you need a break anytime, let me know; we'll take a break. OK?

Q. OK. If you can turn to the, in the upper part of this document, in these documents there's -- it says Mueller MWAP and a number. If you can turn to No. 18.

A. I have a 17 and a 19. Oh --

Q. OK.

A. Sorry. Got it.

Q. A lot of pages here.

If you can look at 18 and 19 and let me know if you recognize what this document is.

A. I'm surprised that my name is on it. It's Green Haven.

Q. Well, what is this document?
A. Oh. It's an MWAP. I'm sorry.
Q. OK.
A. Sorry.
Q. No problem.
And this was a document that was formed as a result of policy 1.24, right?
A. Yes.
Q. OK. And just briefly, the -- let's -- the second -- it says housing location SHU. What does that mean?
A. Special housing unit.
Q. OK. And this request is from -- is for a patient by the name of Hardley Silus, right?
A. Yes. Yes.
Q. OK. And it says a rationale for GP. What does that mean, rationale for GP?
A. General population.
Q. OK. And it says neuropathy. What does that -- when you were reading these documents, what does that mean to you?
A. I think it usually was meant that if this was, for instance, an opioid, whether they should be in a specialized unit, like an infirmary, or whatnot.
Q. OK. But do you know why it says neuropathy there? How did you interpret that?
MS. THOMAS: Objection. Just to the extent that it

assumes that she did interpret that.
A. I don't know how to interpret it. It's not the kind of -- I wouldn't have filled it out that way.
Q. OK. Well, let me -- I guess that's a fair point. Did you review this document and make a determination whether to approve or deny the request coming in for gabapentin?
A. I don't know. That's why I say, because it's Green Haven, so I'm not sure.
Q. OK. OK. Let's -- just so the record's clear, let's look at -- if you can flip to Mueller MWAP page 20, just one page over, we'll try another one. Take a look at this document and let me know if this is a MWAP request form that you made a determination of whether to approve or deny.
A. Probably not. It's Taconic.
Q. It's to what?
A. It's probably not. It's Taconic.
Q. OK.
OK. Let's -- let me find one that there's no question. Let's go to Mueller MWAP page 28.
A. OK.
Q. This is for a medication with abuse potential request form for a Mr. Aaron Dockery from Shawangunk Correctional Facility, right?
A. Yes.
Q. The date of this request was August 8, 2018, right?

A. It says August 19 -- oh, that's his date of birth.

Yes.

Q. Now, reviewing these -- it's two pages, 28 to 29 -- is this a MWAP request form that you reviewed?

A. I would assume so. It's one of my facilities.

Q. OK. And your name is on the bottom as the name of the RMD, right?

A. Yes.

Q. And do you recall -- do you know who Mr. Aaron Dockery is?

A. I recognize the name.

Q. OK. Do you recognize ever being in the same room with him and treating him or having any direct, providing any direct care for Mr. Dockery?

A. No.

Q. And the prescriber from this form requesting an MWAP medication of Neurontin was Dr. Lee, right?

A. Yes.

Q. And Dr. Lee was one of the providers that you mentioned earlier that you had some concerns about?

A. Yes.

Q. When you reviewed MWAP forms submitted by Dr. Lee, were you more -- did you provide more scrutiny on those forms than other, to other providers that you didn't have any concerns about?

MS. THOMAS: I would just object to the extent that

the witness could not recall if she did, in fact, review this form and write in this document, and the question assumes that she did.

THE COURT: I think it actually is a question more generally. It begins, "When you reviewed MWAP forms submitted by Dr. Lee."

MS. THOMAS: Understood.

THE COURT: Overruled.

MS. THOMAS: Thank you.

THE COURT: Yes, ma'am.

BY MR. MORRISON:

Q. When you reviewed forms submitted by Dr. Lee, did you provide more scrutiny to his requests than other providers?

A. No.

Q. You held every provider to the same standard of review of their MWAP requests?

A. Yes.

Q. By the way, who taught you or how did you learn to review these MWAP request forms?

A. I don't know what you mean by that question.

Q. Well, when policy 1.24 came into effect, you were provided this new responsibility of your job, to review these forms, right?

A. Yes.

Q. Were you provided any training at all in how to review

these forms?
A. Not that I recall.
Q. Just told you're going to start getting forms to approve or disapprove medication for patients; do what you want?
A. I don't know what -- do what you want?
Q. Well, there's no standard, there's no requirements that you had to follow into whether making a determination to approve or disapprove?
A. I think as physicians we know what needs to be done.
Q. What do you mean by that?
A. In other words, you review the form and then you review everything you can on the computer and get as much information as you can about each case, each request.
Q. OK. As a physician also you'd want to look at the medical records, right?
A. Well, the records that we could see that were on the computer, yes.
Q. OK. And you would agree that the -- you're talking about the FHS1 system, right?
A. Yes.
Q. And you would agree that the FHS1 system is not the medical records and complete medical chart of the patient?
A. Yes.
Q. You would agree that the FHS1 system is a scheduling tool, for the most part?

A. No.
Q. What would you -- what would you categorize the FHS1 system to be then?
A. It shows you all of the specialty consults, consultations that the patient has had, what testing the patient has had, what appointments at the facility the patient has had.
Q. It doesn't show the results of those testing unless they were entered in, right?
A. Not if they weren't entered in.
Q. And oftentimes, one of the issues that you would have is that providers don't follow up after the consultation comes back with what the specialist recommended and the results; fair?
A. Correct.
Q. OK.
A. And that's why they need to write that on the request.
Q. OK. Now, let's go back to the MWAP request of Mr. Dockery. Do you have any reason to believe that you did not review and make a determination on this MWAP request form?
A. Can I read it?
Q. Of course.
A. No.
Q. No? No what? I'm sorry.
Just to be clear, no reason to disbelieve that you didn't review this and make a --

THE COURT: You had no reason to believe you didn't review this.

MR. MORRISON: Correct.

OK. Now I'm really confused.

MS. AGNEW: I think there's a double negative.

THE COURT: Thank you.

A. I believe I reviewed this.

Q. Thank you. Thank you.

Then it was your determination not to approve, right?

A. Correct.

Q. OK. Let's go over this, try to do it quickly. The first page, completely this first page, do you input any of the information on this first page? And I'm speaking specifically about page 28.

A. I'm sorry. What was the question?

Q. Sorry. The information on page 28, is that inputted into this document by you?

A. No.

Q. OK. And it's fair to say the only input that you put in on this document would be on page 29 in the reviewer comments and the approval?

A. Yes.

MS. THOMAS: I would just object to the extent the witness has not confirmed whether or not she has put those comments in. So to the extent the question assumes that, I

would object.

THE COURT: All right. I think I'll take it for what it's worth.

Go ahead.

BY MR. MORRISON:

Q. So in the first page, when you -- before you make a decision, you read this whole form, right?

A. Yes.

Q. And do you see anything in this form that's missing in regards to Dr. Lee's request to prescribe Neurontin to Mr. Dockery?

A. He didn't fill out -- oh, actually, wait a second. Physical exams and kind of updated information, he pretty much parroted what had come to him from elsewhere. But other than that, it's mostly filled out.

Q. When you say parroted what came to him from elsewhere, are you referring to the section where it says requests for consultation with specialty provider, and he marks yes; and then it says if yes, specify specialty, he writes neurology, continue Tecfidera and Neurontin for hand and feet neuropathy? Is that what he parroted?

A. No. I was thinking more under treatment options.

Q. OK. Oh. So when you -- you think he parroted when he says: Offender was transferred to C-O-X, Cox, which I assume means Coxsackie, infirmary RMU; was consulted to Dr.

Koenigsmann for Neurontin and approved; MRI confirmed presence of multiple subcortical white matter lesions; Neurontin discontinued on July 2018; now offender can't sleep times several days due to pain in hands and foot neuropathy; used walker for ambulatory, used to walk without a walker; tried with Elavil, Tegretol, Cymbalta. Not effective.

You think he was parroting that information or he was providing the information he became aware of as his provider?

A. It's hard for me to tell right now.

Q. OK. Did you believe the information in that treatment option, TEP /step therapy section?

A. I guess some of it.

Q. What part didn't you -- did you believe that his Neurontin was discontinued on July 2018 and now he can't sleep for several days due to his pain in hands and foot neuropathy?

A. Nursing staff was coming forth with different -- with conflicting information.

Q. Did you believe that Mr. Dockery was deteriorating after his Neurontin was discontinued on July of 2018?

A. Medical staff other than Dr. Lee didn't think so.

Q. OK. So who did -- so according to you, you're getting information about Mr. Lee -- Dr. Lee's request for Neurontin, and you're speaking to nursing staff about his patient. Is that accurate?

A. From my comments, it would appear that I had received

information from nursing staff.

Q. So if you're reaching out to nursing staff because, for some reason, you don't trust or you don't believe what Dr. Lee has wrote, why don't you just reach out to the patient himself and talk to him?

A. It was probably the nursing staff that reached out to me.

Q. Probably, or are you just guessing?

A. I -- I don't remember, but the way things -- I don't -- I wouldn't ordinarily reach out to the nursing staff like that.

Q. But you don't remember the nursing staff actually reaching out to you about this request?

A. From what my comments were.

Q. Tell me where in your comments you believe you talked to medical staff.

A. "According to medical staff, does not appear to be in pain but rather malingering and drug seeking; strongly muscled; started bringing walker to medical unit after Neurontin stopped last month."

Q. And this is a man with multiple sclerosis, right?

A. But Neurontin doesn't treat multiple sclerosis.

Q. You're an expert in multiple sclerosis?

A. I'm not a neurologist, but Neurontin is not used to treat multiple sclerosis. The Tecfidera is.

Q. Does Neurontin treat neuropathy in your feet?

A. It's been used for that, but it's an off-label use

currently.
Q. And it's been effective for some people, like Mr. Dockery. Would you agree?
A. I don't know.
Q. And it's fair to say that you did not approve Mr. Dockery being represcribed Neurontin following this MWAP request?
A. Yeah. I said I needed supportive diagnostics and suggested alternative, safer treatment modalities.
Q. OK. Well, the fact that Dr. Lee put in he saw a neurologist who recommended Neurontin for his hand and feet neuropathy wasn't enough for you; is that fair?
A. I don't know that Neurontin was specifically recommended by neurology.
Q. It says it right here on the form, Doctor. Page 28.
A. You mean where it says continue Tecfidera?
Q. And Neurontin.
A. And Neurontin. OK.
Q. For hand/feet neuropathy.
A. OK.
Q. It says that, right?
A. It says that on the form.
Q. OK. After you disapproved this request by Dr. Lee to treat Mr. Dockery with Neurontin, did you follow up, you know, maybe a week later to how Mr. Dockery was responding to any of these alternative medications that you wanted him -- or strike that.

I don't even think you recommended alternative -- strike that.

After you denied or not approved this MWAP form, did you follow up on the condition of Mr. Dockery?

A. I don't know.

Q. Is that something you normally did after you failed to approve or did not approve an MWAP request form, to follow up with the patient?

A. Some of them I would -- some of the providers I would speak with or email or I could look on FH1s to see if they had ordered any testing.

Q. Did you do that with Dr. Lee? Did you call Dr. Lee and say: Hey, I disapproved -- I didn't approve the Neurontin last week; how's Mr. Dockery doing?

A. I don't recall.

MS. AGNEW: Your Honor, can we take five minutes?

THE COURT: Is it all right with you?

MR. MORRISON: It's fine with me.

THE COURT: All right. Would you inform the witness, please.

MR. MORRISON: We're going to take a five-minute break. Is that OK? Do you want a little longer?

(Recess)

THE COURT: Mr. Morrison.

MR. MORRISON: Before I begin, Judge, I do want to

move into evidence exhibit 138 and exhibit 72, which just the pages Bates stamped Mueller MWAP 28 and 29 that we were just discussing.

MS. THOMAS: Could I please start with exhibit 138?

I would object on foundation, as the witness had testified that she hadn't recognized the document, didn't remember seeing the document before, other than when it was submitted to her at her deposition and had no other information other than being walked through the contents of the document rather than independent recollection of the document itself.

I'd also object on the grounds of relevance, as it applies to a time period at least two years before the MWAP period was enacted.

Those are my objections to 138.

MR. MORRISON: Your Honor, she agreed that these were records reflecting the meetings of the narcotics review committee. She testified about the documents, and our case is stating that the policy of discontinuing medications began back in 2015 as a direct result of this narcotics review committee.

(Continued on next page)

MS. THOMAS: In Dr. Mueller's testimony, she was walked through what the different columns stated, and she was asked questions such as: Does this show a discontinuance date? If I looked at this document and it says Final D/C Date, I too could say that. I don't believe that shows an independent——any independent information from the witness. And she also testified that she did not have knowledge of this document otherwise.

THE COURT: My recollection is she said she didn't recognize the document, but I thought that as they went through it, she did acknowledge that these were the results of the meetings on the stated dates.

MS. THOMAS: Respectfully, I believe that her testimony was that that's what it would appear to be from the document. I don't believe that reviewing the document and saying, yes, the document reflects what the question states, after the leading questions that stated that, is evidence of her own understanding of the contents, or validation that the contents are what they say they are.

MR. MORRISON: I believe that the question was: Do you agree that these documents reflect the patients that were reviewed on the first page, 4/15/2015? And she agreed.

THE COURT: Okay. The question, though, is the document. I think the substance of the testimony was that, for example, on April 15 of 2015, 15 of the 16 people who were

considered had final discontinuation dates, but I really don't think that the witness really laid a foundation for the document. So I will affirm the objection.

MS. THOMAS: Thank you, your Honor.

And if I may be heard as to, I believe Exhibit 72, which would be pages Mueller MWAP 28 and 29. I would object to the entrance of this exhibit. There's an issue with this document that had been previously raised. All of the parties are aware of this. If you look at the metadata for the document in question, it actually shows that the last editor of the document was Dr. Bozer, not Dr. Mueller, and as Dr. Mueller originally testified, she did not recall this particular document, so I would object on the grounds that the metadata for the document itself reflects a different author than Dr. Mueller, and she did not have a sufficient recollection to show that she did in fact write this document.

MR. MORRISON: I think the opposite was the testimony, that she did, not that she didn't review this document and not approve it.

MS. THOMAS: Respectfully, Dr. Mueller was asked a series of leading questions, which I'm not objecting to those questions per se, but she was asked questions after information was read to her. So she was led to believe that this was her writing but originally testified——and if we go back to what she originally testified, she did not recall writing this document

or having seen it before.

MR. MORRISON: Personally, I don't recall any confusion about whether she approved this document or not. In fact, I think I went through two where she didn't recall until I landed on this one.

THE COURT: We'll review the transcript overnight, and just remind me in the morning, please.

MS. THOMAS: Yes, your Honor.

I just also would like to identify that the two other pages that were raised were MWAP 18 and MWAP 20. Those also have the same metadata issues that we discussed earlier today and relate to that. I just wanted to put that on the record.

THE COURT: I don't think counsel was offering them.

MS. THOMAS: I understand. I just wanted to make it clear that there was testimony as to those documents, so I just wanted to raise that as that was discussed this morning as well.

THE COURT: Okay.

MS. THOMAS: Thank you, your Honor.

MR. MORRISON: May I proceed?

THE COURT: Yes, sir.

BY MR. MORRISON:

Q. Dr. Mueller, do you have any idea how many MWAP medication request forms you did not approve?

A. No.

Q. Did you ever do any research or investigate how many MWAP request forms you didn't approve?
A. No.
Q. Were you ever informed by anyone——or strike that.
Did anyone ever review your MWAP request forms, to your knowledge?
A. Not to my knowledge.
Q. Okay. Was there any person overseeing to make sure that your approvals or disapprovals were appropriate?
A. I don't know.
Q. Okay. It's true that between——some facilities, by the end of the MWAP policy, which would be February of 2022, got their prescription Neurontin levels down to 0 in their facility; would you agree with that?
A. I wouldn't know.
Q. Okay. You're not aware that Wallkill, Wallkill Correctional Facility, actually got their Neurontin prescriptions in that facility to 0?
A. Not aware.
Q. Now briefly, I want to talk about the end of the MWAP policy. You're aware that occurred in early February of 2022?
A. Yes.
Q. And were you involved in the creation of the new policy at all?
A. No.

Q. Do you know why you weren't involved in the creation of the new policy?
A. No.
Q. What is your understanding of why the MWAP policy was terminated?
A. I believe it came out as a result of this suit.
Q. Okay. And when the new policy, 1.24A, started, did you conduct any training or provide any information to any of the medical providers in your hub?
A. What kind of training?
Q. Regarding the new policy, 1.24A, and how to prescribe medications with abuse potential.
A. I can only conduct that kind of training at the direction of the CMO.
Q. Okay. And were you ever directed by the CMO at any time to train your providers and make sure that they are aware and abiding by policy 1.24A provisions?
A. Could you repeat that.
Q. Sure. Did the CMO, at any time after policy 1.24A came into effect, direct you, as the RMD, to make sure that the providers in your hub are aware of policy 1.24A and following the provisions?
A. I don't believe so.
Q. Okay. Do you do anything as a clinical supervisor today to ensure compliance of the providers with policy 1.24A?

A. As the RMD?
Q. Yes.
A. No.
Q. It's not part of your job, correct?
A. Correct.
Q. Are you aware of whose job that is at all?
A. I know that the SURNs are conducting audits continuously in all of the facilities to assure that they are in compliance with 1.24A.

MR. MORRISON: One second, your Honor.

Q. To go back one more second regarding the MWAP request forms that you disapproved because they weren't completed correctly by providers——do you remember that testimony we were talking about?
A. Yes.
Q. After you were presented with one of these forms and they weren't completed correctly, did you go back and call the providers and train them and tell them what is missing and what you need in regards to each request form?
A. Yes.
Q. And following that, did that fix the problem?
A. With some, yes; with others, no.
Q. Okay. And then you would continue——strike that.

MR. MORRISON: Nothing further. Thank you, Doctor.

THE COURT: Cross-examination, please, counsel.

MS. THOMAS: Thank you, your Honor.

THE COURT: Ms. Thomas.

MS. THOMAS: Thank you, your Honor.

CROSS EXAMINATION

BY MS. THOMAS:

Q. Dr. Mueller, can you hear me okay?

A. Yes. Thank you.

Q. Great. Thank you very much.

My name is Jennifer Thomas, and I represent Dr. Carol Moores in her official capacity as the Chief Medical Officer for the Department of Corrections, and I have a few questions for you today.

You're currently an RMD with the Department of Corrections, right?

A. Yes.

Q. Do you currently treat any patients?

A. No.

Q. Do you currently perform any physical exams of patients?

A. Not unless a provider in a facility asks me to go with them to see a patient, but not as a routine.

Q. Are any individual patients assigned to you currently?

A. No.

Q. And in what year did you last treat patients at DOCCS?

A. As a regular, ongoing——

Q. Yes.

A. Well, that would have been when I became an RMD.
Q. And is that approximately 2012-2013?
A. Yes. Probably more 2013, I think.
Q. Okay. Thank you.
And do you currently prescribe any medications to any patients at DOCCS?
A. No.
Q. And in what year did you last prescribe medications to patients at DOCCS?
A. I don't know.
Q. Would that have been around the same time as you transferred to be an RMD?
A. Yes, but sometimes a circumstance comes up where we're asked to because the provider is not available or whatnot, so if there was something anecdotal, I don't recall when that would have been.
Q. Okay. But in your regular day-to-day duties it doesn't include prescribing medications currently?
A. That's correct.
Q. Okay. Do you currently review any prescriptions written by other providers?
A. No.
Q. Do you currently review any nonformulary requests?
A. No.
Q. To the best of your understanding is the MWAP policy still

in effect at the hub that you are in charge of?
A. Is the MWAP still in effect?
Q. Yes.
A. No.
Q. And is the MWAP policy still in effect at DOCCS?
A. No.
Q. Do you currently review any MWAP requests?
A. No.
Q. Earlier you had testified about certain events at Green Haven, right?
A. You mean that review committee?
Q. Yes.
A. Yes.
Q. In what year did those meetings occur, to the best of your recollection?
A. I think it was 2015.
Q. And you testified earlier about events at Greene Correctional Facility, right?
A. Yes.
Q. And what year did those events occur?
A. I don't know.
Q. Was that approximately around 2015 or 2016?
A. I really would be guessing.
Q. Okay. And just to confirm, what year was MWAP implemented?
A. 2017.

Q. And in what year was MWAP repealed?
A. 2020.
Q. Was it February 8, 2021?
A. I don't know the exact date, and I do know it was in February.
MS. THOMAS: Okay. Thank you. I have no further questions.
THE COURT: Redirect, counsel?
MR. MORRISON: Nothing based on that. Thank you. Thank you, Dr. Mueller.
THE COURT: You may step down, ma'am.
Counsel?
MS. THOMAS: You may step down.
(Witness excused)
MS. AGNEW: Your Honor, if we could please just——and I'm not casting aspersions on Ms. Thomas, who is an excellent lawyer and doing an excellent job, but my team just pulled up the original Excel file that was produced to us by DOCCS for the exhibit at Mueller MWAP 28-29, and the metadata actually shows it was authored by Susan Mueller. We're happy to show that to counsel, meet and confer, and come back to you in the morning, before you go through the mayhem of reviewing the transcript. It's up to you.
MS. THOMAS: If I may, just for the record, I'm looking at the exact same document, and she's correct that it

does say the author is Susan Mueller, but it says it was last modified by Paula Bozer. So that's what the clarification is. We're both looking at the same document. We're having a little dispute as to what those terms mean, but I just wanted to clarify.

THE COURT: All right. Why don't you folks look at it tonight and let me know.

MS. THOMAS: Certainly.

MS. AGNEW: Okay. Very good. Thank you, your Honor.

THE COURT: Is there anything else you want to do on the record?

MS. AGNEW: Not from the plaintiff class, your Honor. Thank you.

MS. THOMAS: Nothing on this issue. Thank you.

THE COURT: Okay. Off the record.

(Discussion off the record)

MS. AGNEW: Okay. Plaintiffs call Dr. Dinello.

THE COURT: Ms. Agnew.

MS. AGNEW: Just one moment, your Honor.

DAVID DINELLO MD,

called as a witness by the Plaintiff,

having been duly sworn, testified as follows:

DIRECT EXAMINATION

BY MS. AGNEW:

Q. Good afternoon, Dr. Dinello.

A. Good afternoon.
Q. We do apologize to you for the delay. We've been trying to move things along.
A. That's okay. Doctors can't complain about making people wait.
Q. Okay. Here we go.
Dr. Dinello, do you know who I am?
A. Yes, ma'am.
Q. Who am I?
A. Ms. Amy Agnew.
Q. And what do I do?
A. You are a lawyer.
Q. Okay. I want you to just look at what I've premarked as P139 in that pile. And it may be out of order, and for that I apologize.
A. Okay. P139.
Yes.
Q. And you know, given our history, that I review your emails, correct?
A. Yes, ma'am.
Q. And what is our history?
A. We go way back for years with different cases.
Q. Okay. Can you look at P139, sir, and tell me, do you recognize that document?
A. It looks like an email, yes.

Q. Okay. And are you an author of that email?
A. I am on this email, yes.
Q. Okay. And isn't it true this is an email exchange between you and Dr. Christopher Wright at Five Points Correctional Facility?
A. Yes.
Q. And the exchange is roughly dated July 21st of 2020?
A. Yes, ma'am.
Q. Okay. And in this email do you tell Dr. Wright, "Unfortunately, there are some very unhealthy and liberal lawyers that see DOCCS as easy pickings and continually present lawsuits. The MWAP policy and the way DOCCS approaches chronic, nonpalliative care is currently in their crosshairs. We will keep everyone abreast of changes as they occur." Did you write that, sir?
A. Yes, ma'am.

MS. AGNEW: Your Honor, permission to treat the witness as hostile.

THE COURT: Any objection?

MS. THOMAS: I would object because he hasn't shown that he's hostile. Other than reading the contents of an email, he himself has not testified to anything that would demonstrate that he's a hostile witness at this point, and it's plaintiff's own witness.

THE COURT: Ms. Agnew.

MS. AGNEW: Your Honor, David Dinello is most certainly a hostile witness. I can keep going if we like, but I don't think it's necessary.

THE COURT: Ms. Thomas, go ahead.

MS. THOMAS: I'm not sure what the response to my argument is, other than your characterization that he's a hostile witness, but I'd be happy to hear what the argument for why he's a hostile witness is.

BY MS. AGNEW:

Q. All right. Dr. Dinello, in your email were you referring to me when you said "unhealthy and liberal lawyers that see DOCCS as easy pickings"?

A. No.

Q. You weren't?

A. Not you only.

Q. Okay. But I was among the lawyers you were referring to, correct?

A. Probably, yes.

Q. Okay. And isn't it true you've told me previously that in fact you were referring to me in this email?

A. I believe one email. I don't know if it was this one, but yes.

Q. Okay. And so, Dr. Dinello, can we agree that in July of 2021 there were some reassessments going on for patients who were involved in this litigation?

A. In July of 2021?
Q. I'm sorry. July of 2020.
A. Maybe. If you say so.
Q. Why don't you review the email.
A. Let's see.
I don't know if it was a reevaluation. He saw the patient. He talked about his chronic pain. I don't know if it was characterized as a reevaluation or not.
Q. Can you tell me, isn't it true, reading this email, that Dr. Wright was reaching out to you about the re-prescription of Neurontin to a Mr. Harold Ortiz?
MS. THOMAS: Objection to the extent that this document is not admitted as an exhibit at this point.
THE COURT: Okay. Off the record.
(Discussion off the record)
THE COURT: Are you moving the exhibit?
MS. AGNEW: Yes, your Honor. I'm going to move to admit Plaintiff's P139 into evidence.
MS. THOMAS: We do not object to the exhibit.
THE COURT: Received.
(Plaintiff's Exhibit 139 received in evidence)
MS. AGNEW: Very good.
BY MS. AGNEW:
Q. Dr. Dinello, looking at this email, isn't it true Dr. Wright was looking——he was writing you about the

prescription of Neurontin to Mr. Harold Ortiz?
A. I see his name at the top. He was referring about that patient. He was talking about the medical care of that patient, yes.
Q. Okay. And specifically isn't he asking you about the prescription of Neurontin for that patient?
A. Let's see. He mentions Naprosyn, Tegretol, gab——gabapentin is mentioned, Neurontin is mentioned, yes.
Q. Okay. And do you have any reason to believe that this email wasn't in response to a reassessment that was part of this litigation?
A. I have no idea why this was generated by Dr. Wright.
Q. Okay. Dr. Dinello, have you previously served as a regional medical director for New York State DOCCS?
A. Yes, ma'am.
Q. Okay. Give us the years that you served as a regional medical director.
A. 2014 to 2021.
Q. Okay. And isn't it true you started working in DOCCS around 2009?
A. No. It was 2006 or 7, as a moonlighting physician.
Q. Then you became part time in 2009, correct?
A. Yes, ma'am.
Q. Okay. And then you became a full-time physician in 2011, correct?

A. Around then, I think, yes.
Q. Okay. And you became a full-time physician after you had medical licensing issues; is that correct?
A. No. I don't really know, in all honesty.
Q. Is it true that you voluntarily gave up your license to practice emergency medicine as part of a consent agreement?
A. No. It was voluntary limitation. You don't give it up; you just limit——limit yourself, not to work with the ER.
Q. What does a voluntary limitation mean?
A. I promised them I'm not going to look to work in the emergency room——
Q. Okay.
A. —— as an attending physician.
Q. In fact, can you walk into an emergency room and serve as an emergency room physician?
A. Yes.
Q. Right now.
A. In Maryland and West Virginia, yes.
Q. Okay. In the state of New York, can you serve?
A. No, ma'am.
Q. Can you do so in the state of Pennsylvania?
A. No, ma'am.
Q. Why not?
A. Because the restriction carries there too.
Q. Okay. And then as also a product of that proceeding and

your agreement, you also were supervised by another doctor for three years, right?

A. Yes.

Q. And during that time you worked for DOCCS, correct?

A. Yes.

Q. Okay. And who supervised you during that three years?

A. The regional medical director, Marshall Trabout, for my corrections work; and for my addictions work, it was Hannah McAdams (ph).

Q. Okay. And so was there some kind of reporting or something that happened as part of that oversight?

A. Yes, quarterly reporting was sent to the OPMC, which is the Office of Professional Medical Conduct.

THE COURT: Sir, may I ask you to slide in a little closer to that microphone, please.

THE WITNESS: Sure. Sure thing.

Q. Okay. So as I understand it, you served as a treating physician in DOCCS, then full-time from 2011 until you resigned; is that correct?

A. Yes.

Q. And just so the Court knows, when did you resign?

A. In April 1, 2021.

Q. And just to put this in the time line, the MWAP policy was rescinded on February 8th of 2021; is that correct?

A. If you say so. I'm not sure of the exact date.

Q. Okay. And can you tell me, in your role as a treating physician, were you working with patients on the facility level?
A. Yes.
Q. Were you prescribing medications?
A. Yes.
Q. Okay. And then when you became an RMD, did you continue to prescribe to patients and facilities?
A. Yes.
Q. In what circumstances?
A. When they didn't have a physician, which was many of them; where I saw patients, Five Points, Auburn; I even saw patients when I went up to north country and Altona Correctional Facility; I even saw patients at Watertown and——all over the state, barely.
Q. Okay. When you saw patients at these different facilities——I'm sorry. Is it your testimony there was no doctor at the facility?
A. There might have been a midlevel provider or I was there and there was no doctor and there was somebody needed to be seen and so they asked me to see them.
Q. Okay. And then when you served as an RMD, can you just tell us, in the beginning, which hubs did you cover?
A. The Elmira and Oneida hubs.
Q. Okay. Was there another point in time in which you were

not assigned but rather you volunteered to be oversight of other hubs?

A. Yes.

Q. Which were those hubs?

A. The Watertown and Clinton hubs.

Q. So isn't it true during the pendency of the MWAP period——and I'm just going to call that June 1st of 2017 until it was rescinded——that you were generally the RMD for four DOCCS hubs?

A. More or less, yes.

Q. Okay. And so that means you had the oversight of approximately 20 prisons, correct?

A. Yes.

Q. And was that a substantially larger number than any other RMD had?

A. I believe so, yes.

Q. So the impact of any policies or practices you put into place in those facilities would have a greater DOCCS-wide impact; would you agree with that?

A. Yes.

Q. Okay. So let's talk about the MWAP policy itself for a moment.

MS. AGNEW: And I'm just going to caution you, we're not going to finish today, but we're going to get started and then we're going to find a way to get you back, okay?

Q. Let's talk about the MWAP policy itself. Is it true you worked on the policy development for two years before it was promulgated?

A. I don't know exact time frame, but it was a while beforehand.

Q. Okay. And was that as part of your role as the policy and review committee chairperson or did you bring that as an extra project to that committee?

A. I did serve on the policy and review committee. I don't know exactly what those dates were, so I'm not too sure.

Q. Okay. And is it true around the same time frame you were also chairman of the pharmaceuticals and therapeutics committee?

A. Yes.

Q. Do I have the name right?

A. Yes.

Q. Okay. So you were the chair of the department that decided which drugs went on the formulary; is that correct?

A. Yes.

Q. And during some of that same time you were also the chair of this policy review committee; is that correct?

A. No, I don't think I was the chair. I was just one of the team members.

Q. Okay. And so how did it come to be that you assumed control of the MWAP policy development?

A. I don't know how. It just happened. Maybe because I'm the one that decided to——to take control of it and be the forefront to write it.

Q. Okay. When you say, "I'm the one who decided to take control of it," was that because it was your idea?

A. No. We talked about it, the regional medical directors and a number of other people, the chief medical officer, and we decided that we'd——something should be addressed.

Q. Okay. Isn't it true, though, you brought it to Dr. Koenigsmann first and he actually decided it wasn't a good idea at that time and then you reapproached him later and then he said okay?

A. I don't believe that's the case, no. I didn't take it to him first, I don't think. He——no, he never turned it down, then it got revisited. No, not to my knowledge.

Q. Okay. Can you explain to the Court why it was determined to make the MWAP, let's say, criteria or scheme a policy rather than a clinical guideline?

A. A policy has more teeth and it has to be followed, where guidelines are just guidelines and you can follow them or not follow them.

Q. Okay. And what made you believe that if it was a guideline, providers within DOCCS would not follow it?

A. Because it was happening in the real world with the narcotics and other addictive medications. Guidelines are

everywhere, but yet they're still being written like candy.
Q. Okay. Tell me what's "the real world"?
A. The world outside of DOCCS; the medical world outside of DOCCS, within the United States.
Q. Okay. And you considered DOCCS to be different than the real world because it's a paramilitary organization; is that correct?
A. No, ma'am. I think it's just a slice of the American population, with a higher concentration of people that have serious drug addiction problems.
Q. Okay. But don't you think that DOCCS is operated in a paramilitary fashion and that's why one rung answers to the next rung answers to the next rung?
A. Not necessarily, no. I don't think I believe that.
Q. You don't think you've ever used that term, "paramilitary"?
A. I know I've heard that term, and it makes sense the way DOCCS works. That's how I'd describe DOCCS, as paramilitary, yes.
Q. So you've described DOCCS as paramilitary, correct?
A. I'm sure I have, yes.
Q. Okay. And so tell me your own prescribing practices. You started limiting your prescriptions of medications with abuse potential yourself beginning in about 2015, correct?
A. No, I don't——I think I always have been pretty conservative with medicines that are addictive and habit forming, almost my

entire career. I was trained that way at Penn State.
Q. Okay. So there was no time when you started paying particular attention to the types of medications you were prescribing within DOCCS facilities?
A. I'm sure there was a time I paid more attention to that, especially as the national epidemic was brought to our attention.
Q. Okay. Were you prescribing MWAP medications pretty regularly within the facilities?
A. I don't believe so. I'm not too sure.
Q. Okay. Can you tell me, did there come a time in your kind of regime as the RMD of some of these hubs when you started encouraging your providers to "think of alternatives to prescribing MWAP medications"?
A. Did I have that conversation, with providers?
Q. Yes.
A. Oh, yes.
Q. And you had it quite widely, correct?
A. Oh, yes.
Q. Okay. And so how would you encourage these providers to change their own prescribing practices?
A. It was——just gave them alternatives to treat pain and actually get to the bottom of the real pain and fix it and not mask it with medications. I always encourage patients, let's find the nonpalliative chronic pain and let's fix it, not just

keep masking it and medicating it. Let's get to the bottom of it and see if we can take it away totally, which isn't really possible totally.

Q. So let's just start to think about this. When you put together the MWAP policy, how did the provisions of that policy encourage providers to start finding alternatives?

A. I don't know, besides it——I don't know how it encouraged them.

Q. Okay. So if I understand, you were encouraging providers before MWAP to change their prescribing practices, correct?

A. Yes.

Q. Were those encouragements successful?

A. I'm not sure if they were or not.

Q. Okay. So you would talk to a given provider but you would have no idea of what the effect of your conversations or your persuasion would have on him or her?

A. I'm not too sure if it had an effect or not. I believe so. I'm not really sure. I didn't really follow up with them.

Q. Okay. So you had no interest, is it your testimony, in their prescribing practices pre-MWAP?

A. I always have——as a medical——the regional medical director, you have to be concerned about all the practices of your providers. That's kind of what you do when you review charts and you have to do performance evaluations and things like that.

Q. Okay. So how would you know any given provider needed persuasion to choose different prescribing practices if you weren't aware——

A. They would come to me and ask for guidance.

Q. Okay. So they were coming to you and saying, *Dr. Dinello, I don't know what to do*?

A. No.

Q. *Can you tell me what to do*?

A. No.

Q. Okay. So tell me how they would come to you and ask, generally.

A. They would generally ask other suggestions to treat certain painful conditions, what other means we had at DOCCS at our disposal.

Q. Okay. And did each of these providers have access to a copy of the formulary?

A. I'm sure they did, yes.

Q. Okay. So why wouldn't they know other alternatives available within DOCCS?

A. Because the formulary just contains medications. The medication is just a small part of how you treat pain. There are a dozen other things we use to treat pain.

Q. Okay. So I just want to clarify your testimony. They were coming to you to look for things other than pharmaceuticals?

A. Other than med——sometimes medications, but other modalities

that were safer alternative.
Q. Okay. And what were those other modalities that they wouldn't know of within DOCCS?
A. They might not know, realize TENS units might be beneficial; they might not realize other medications, like Cymbalta, can be useful for chronic neuropathic pain; Topamax can be used; also, they weren't too sure, some of them, of different orthotics we could use in DOCCS, what would be useful; referrals to specialists who we had available in certain hubs, if we had access to certain specialists. There was a variety of things.
Q. Okay. So it's your testimony that providers wouldn't know about the utility or availability of TENS machines?
A. They wouldn't know if they're allowed in DOCCS. Based on the wiring and some of the newer doctors and providers, which are a lot of them over the years, weren't too sure what was allowed or what wasn't allowed.
Q. Were there facilities within your hubs that didn't have TENS units?
A. There are some that did not use it, yes.
Q. Okay. And so you would encourage them to look at these alternatives——two of which I note are medications——correct?
A. If you say two, yeah. I'm not too sure.
Q. I think you just said Tegretol and Cymbalta.
A. No. Topamax, I think. Tegretol can be used too.

Q. Okay. All right. We got three now. Good.

So how——and forgive me for circling back. I'm just wondering, if you're in charge of your facilities and you're paying attention to these providers, how do you not know if these persuasive conversations you're having were having an impact on prescribing practices?

A. I never looked into it.

Q. Okay. So did you have any data on prescriptions or prescribing practices?

A. Gabapentin was probably the——the one that comes to mind the most, and obviously we were always aware of the controlled substances——Tylenol with codeine, OxyContin, anything that's on the federal drug list. We were pretty aware of what's being used and what's not being used.

Q. Okay. And so how did you become aware of data on Neurontin prescriptions?

A. Oh, it's well documented throughout the country, in various states and prison systems, and it's well documented. And not only that, personal testimony from probably hundreds, if not thousands of recovering patients who are also inmates that I've gotten to know in my 17 years of being an addiction specialist. So——

Q. Okay. I'm not talking about the real world; I'm talking about in DOCCS.

A. In DOCCS. These patients were in DOCCS and told me how

they would use it. In fact, DOCCS, gabapentin used to be what we call a self-carry medication. It was so widely abused and diverted that security said, enough is enough, we have to make this a nurse med, and then we eventually had to crush it because hundreds of people were caught cheeking it and selling it on the block. That's well documented. I've seen it dozens of times myself.

Q. Okay. What are you——I'm asking about data. I'm asking about hard data that you reviewed created by DOCCS about numbers of Neurontin prescriptions within DOCCS, not anecdotal evidence. Hard data.

A. I personally saw it. That's as hard as it gets. Many times. Many times. I personally saw people cheeking the medication.

Q. Dr. Dinello, please listen to the question and try to answer it. Don't elicit anything else you need to add, okay?

When did you see hard data on Neurontin? Whether it was diversion numbers, abuse numbers, prescription numbers, data derived from DOCCS.

A. Besides witnessing it on camera personally, no numbers, hard numbers, no.

Q. Okay. When you say on camera, how many videos did you review that you believe constitute data, systemwide data, on Neurontin?

A. I'm not sure off the top of my head. I'd say——I'm not

really sure. I've seen so much video over the years. I don't really know how much.

Q. Okay. So who created some data somewhere based on those videos?

A. I don't know if it was ever taken down and——and put in a form.

Q. Okay. And how would you come to review those videos?

A. Usually someone from security would alert us to a problem that they're seeing, that they're having, and the people they're catching.

Q. Okay. So you're part of the disciplinary process for security?

A. No.

Q. Okay. So forgive me. It's not clear to me why a doctor would be brought in to review a video as part of a disciplinary proceeding.

A. It wasn't——I don't know if it was used for disciplinary reasons. I don't know what that video was used for.

Q. Okay. But you think at some point you may have reviewed some video, but you don't know how many and you don't know when, correct?

A. I don't know when, no.

Q. Okay. So we've got some maybe video, and we've got some anecdotal things, correct?

A. If you say so. Anecdotal, yeah.

Q. Okay. But at no time were you ever presented with any real data, correct?
A. Just the stuff that I saw personally.
Q. Okay. So let's talk about——there was a time, right, when Dr. Trabout sent you down to Elmira Correctional Facility to try to deal with what he considered to be an overprescription of opioids, correct?
A. Yes.
Q. Okay. And that was around 2011, correct?
A. If——yeah, if you say so.
Q. Okay. So you spent some time actually at Elmira, right, meeting with patients; is that correct?
A. Yes, ma'am.
Q. And you believed it was your marching orders to try to move those patients off of opioids and on to alternative treatment modalities; is that correct?
A. I wouldn't say marching them off opioids. That's——trying to find safer treatment modalities for these patients that weren't habit forming, yes.
Q. But Dr. Trabout was worried about the number of opioid prescriptions at Elmira, correct?
A. I would assume so. That's why he sent me down, yes.
Q. And as part of that process, did you talk to the actual prescribing providers about their overprescriptions?
A. Yes, I——yes, I did. I believe so. I don't know if it was

my time as the doctor or just within the regional medical director, but I may have had discussions with providers.

Q. I'm talking about Elmira, 2011.

A. I believe so, yes.

Q. Okay. And then later, in approximately 2015, you served on the narcotics review committee at Green Haven, correct?

A. If——yeah, if it was 2015. I was there, but I don't know exactly what time, what year.

Q. Okay. You were there. And can you tell the Court what you believed the marching orders were for the narcotics review committee. What did you do?

A. It was really no marching orders. It was just a review of patients' medications to make sure that they were on safe medications and there was no safer alternative that wasn't habit forming or addictive.

Q. Okay. And you believed that this was a by-product of the termination of the *Milburn* consent decree, correct?

A. That's what I was told, yes.

Q. Okay. And how did you understand that the termination of *Milburn* had something to do with discontinuing patients from medications at Green Haven?

A. Just because it came coincidentally. *Milburn* ended, and they——I think there was a concern they——there was like 500 Perc tins, Percocet tins missing, and I think that prompted a big audit, and I got asked to take a look at the patients and——

Q. Wasn't it 9900 Percocets that went missing?
A. It could be. It was a lot. I don't know exactly the number.
Q. And wasn't it found it was actually a nurse who had diverted those Percocets, correct?
A. I really have no idea who was——I did hear a nurse, though; you're right. But I didn't——at the time I didn't really know who took them.
Q. Okay. So——
THE COURT: When you get to a convenient point to end, let me know.
MS. AGNEW: I think it's convenient.
THE COURT: All right. Would you people confer with Dr. Dinello and let me know when we're going to resume him, please.
MS. AGNEW: We can, your Honor. Thank you.
THE COURT: Good afternoon, friends. I'll see you in the morning.
(Discussion off the record)
(Adjourned to September 7, 2023, at 9:00 a.m.)

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